***To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!***

NAME:_____ LEISURE ACTIVITIES:_____

OCCUPATION:_____

ALLERGIES: List any medication(s) you are allergic to:_____

Are you latex sensitive? Yes☐ No☐ List any other allergies we should know about_____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes☐ No☐

**Please check any of the following whose care you're under**

☐Medical doctor (MD) ☐Psychiatrist/Psychologist ☐Other
☐Osteopath ☐Physical Therapist
☐Dentist ☐Chiropractor

**If you have seen any of the above during the <u>past three months</u>, please describe for what reason (illness, medical condition, physical, etc.):**

_____

_____

**Have you EVER been diagnosed as having any of the following conditions? (Please circle yes or no)**

YES☐ NO☐ Cancer If Yes, describe what kind:_____
YES☐ NO☐ Heart Problems
YES☐ NO☐ High blood pressure
YES☐ NO☐ Circulation problems
YES☐ NO☐ Asthma
YES☐ NO☐ Emphysema/Bronchitis
YES☐ NO☐ Chemical dependency (i.e., alcoholism)
YES☐ NO☐ Thyroid problems
YES☐ NO☐ Diabetes
YES☐ NO☐ Multiple sclerosis
YES☐ NO☐ Osteoporosis
YES☐ NO☐ Rheumatoid arthritis
YES☐ NO☐ Other arthritic conditions
YES☐ NO☐ Depression
YES☐ NO☐ Hepatitis
YES☐ NO☐ Tuberculosis
YES☐ NO☐ Stroke
YES☐ NO☐ Kidney disease
YES☐ NO☐ Anemia
YES☐ NO☐ Epilepsy
YES☐ NO☐ Other

**<u>For Office Use</u>**

**During the Past month have you been feeling down, depressed or hopeless?** YES☐ NO☐
**During the Past month have you been bothered by having little interest or pleasure in doing things?** YES☐ NO☐
**Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?** YES☐ NO☐
**FOR WOMEN: Are you currently pregnant or think you might be pregnant?** YES☐ NO☐

**Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:**

| | DATE | REASON FOR SURGERY/HOSPITALIZATION |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |
| 6. | _____ | _____ |

**Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:**

| | DATE | INJURY | | DATE | INJURY |
|---|---|---|---|---|---|
| 1. | _____ | _____ | 3. | _____ | _____ |
| 2. | _____ | _____ | 4. | _____ | _____ |

**Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?**

YES☐ NO☐ Diabetes
YES☐ NO☐ Tuberculosis
YES☐ NO☐ Heart disease
YES☐ NO☐ High blood pressure
YES☐ NO☐ Stroke
YES☐ NO☐ Kidney disease
YES☐ NO☐ Alcoholism (chemical dependency)
YES☐ NO☐ Cancer
YES☐ NO☐ Arthritis
YES☐ NO☐ Anemia
YES☐ NO☐ Headaches
YES☐ NO☐ Epilepsy
YES☐ NO☐ Mental illness

**Which of the following OVER-THE-COUNTER medications have you taken in the last week?**

YES☐ NO☐ Aspirin
YES☐ NO☐ Tylenol
YES☐ NO☐ Advil/Motrin/Ibuprofen
YES☐ NO☐ Laxatives
YES☐ NO☐ Decongestants
YES☐ NO☐ Antihistamines
YES☐ NO☐ Antacid
YES☐ NO☐ Vitamins/mineral supplements
YES☐ NO☐ Other_____

**For Office Use**

**Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches):**

1._____ 3._____ 5._____
2._____ 4._____ 6._____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

**Have you recently noted:**

YES☐ NO☐ weight loss/gain
YES☐ NO☐ nausea/vomiting
YES☐ NO☐ dizziness/lightheadedness
YES☐ NO☐ fatigue
YES☐ NO☐ weakness
YES☐ NO☐ fever/chills/sweats
YES☐ NO☐ numbness or tingling
YES☐ NO☐ bowel/bladder irregularity

**For Office Use**

_____
Therapist signature Date

_____
Patient signature Date