To ensure that 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: _____ Right or Left Handed:_____

Allergies: List any medications you are allergic to:_____
_____

Are you latex sensitive? Yes No List any other allergies we should know:_____

Please check any of the following whose care you are currently under:

_____Medical Doctor (MD)	_____Psychiatrist/Psychologist	Other:_____
_____Osteopath	_____Physical Therapist	_____
_____Dentist	_____Chiropractor	

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

Have you EVER been diagnosed as having any of the following conditions?

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 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 Anxiety Disorder
Yes No Other

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 fracture, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____

Please list any medications (prescription or over the counter) you are currently taking (including pills, injections, and/or skin patches):

1. _____ 2. _____ 3._____

4. _____ 5. _____ 6. _____

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

How many packs of cigarettes do you smoke per 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? _____

How many days per week do you use marijuana, cocaine, crack, acid, etc.? _____

Have you recently noted:

Yes	No	Weight loss/gain
Yes	No	nausea/vomiting
Yes	No	fatigue
Yes	No	weakness
Yes	No	fever/chills/sweats
Yes	No	numbness or tingling

_____ _____

Patient signature Date

_____ _____

Therapist signature Date