

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: _____

<p>Allergies: List any medications you are allergic to: _____ _____</p> <p>Are you latex sensitive? Yes No List any other allergies we should know: _____</p>

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:

<u>DATE</u>	<u>REASON FOR SURGERY/HOSPITALIZATION</u>
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:

<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
_____	_____	_____	_____
_____	_____	_____	_____

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

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 |

RATE YOUR PAIN TODAY ON A SCALE FROM 0 TO 10 ON THE LINE BELOW

0 (NO PAIN) _____ **10 (UNBEARABLE PAIN)**

Patient signature

Date

Therapist signature

Date