



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 are under:

_____ Medical Doctor (MD) _____ Psychiatrist/Psychologist Other _____

_____ Dentist _____ Physical Therapist

If you have seen any of the above during the past three months, please describe for what reasons (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 Chemical dependency (i.e., alcoholism)
YES	NO	High blood pressure YES NO Multiple sclerosis
YES	NO	Circulation problems YES NO Rheumatoid arthritis
YES	NO	Asthma YES NO Other arthritic conditions
YES	NO	Emphysema/bronchitis YES NO Depression
YES	NO	Thyroid problems YES NO Hepatitis
YES	NO	Diabetes YES NO Tuberculosis
YES	NO	Multiple sclerosis YES NO Stroke
YES	NO	Kidney disease YES NO Anemia
YES	NO	Epilepsy YES NO Other

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:

<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 fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY
_____	_____
_____	_____
_____	_____

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

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

Please list any PRESCRIPTION medication 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 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

Therapist signature

Date

Patient signature

Date