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: _________________________________ Occupation: ______________________________

Height: ____________ Weight: ___________ Age: ______________ Gender: ____________

Leisure Activities: ____

Allergies: List any medications you are allergic to: ____

Are you latex sensitive? Yes No List any allergies we should know about: _________________

Have you declared the Advanced Clinical Directive or a DNR? YES NO

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

__Medical Doctor __Psychiatrist/Psychologist __Neurologist __Osteopath __Physical Therapist
__Pain Management __Dentist __Chiropractor Other______________

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

____

____

Have you had any in-home physical, occupational, or speech language therapy this year? YES NO

Have you had any outpatient physical, occupation, or speech language therapy this year? YES NO

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

YES NO Cancer, if YES, describe: ____

YES NO Heart Problems, if YES, describe: ____

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	Chemical Dependency (i.e., alcoholism)	YES	NO	Hepatitis
YES	NO	Thyroid Problems	YES	NO	Tuberculosis
YES	NO	Diabetes	YES	NO	Stroke

Therapist Initials: _______

YES	NO	Kidney Disease	YES	NO	Other
YES	NO	Anemia			______________________________________
YES	NO	Epilepsy			

During the past month, have you been feeling down, depressed, or hopeless? YES NO

Recently 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 or tried to injure you in any way? YES NO

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 HOSPITALIZATION/SURGERY
1.	__________________	____
2.	__________________	____
3.	__________________	____
4.	__________________	____

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

DATE	INJURY	DATE	INJURY
__________	____________________	___________	______________________
__________	____________________	___________	______________________
__________	____________________	___________	______________________

Has anyone in your immediate family (parents or siblings) ever been treated for 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
YES	NO	Mental Illness						

Which of the following OVER-THE-COUNTER medications have you taken in the past week? (Circle all that apply)

Aspirin	Advil/Motrin/Ibuprofen	Vitamins/Minerals/Supplements	Decongestants
Antacids	Tylenol	Laxatives	Antihistamines

Other ____

Therapist Initials: _______

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

1. ________________________________ 4. ____________________________________
2. ________________________________ 5. ____________________________________
3. ________________________________ 6. ____________________________________

How many caffeinated coffee or caffeine containing beverages do you drink daily? __________
How many packs of cigarettes do you smoke daily? ____________________
How many days per week do you drink alcohol? _____________________
If one drink equals one beer or glass of wine, how many do you drink at an average sitting? __________

Have you recently experienced any of the following symptoms:

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

Please indicate on the line your current pain level in relation to the two extremes:

Therapist Signature: ____________________________________ **Date**: ___________________

Patient Signature: ______________________________________ **Date**: ___________________

Therapist Initials: _______