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

Name: _____ Date of Birth: ____ / ____ / ____ Age: _____

Marital Status: _____ Religious Affiliation: _____

Gender: Male / Female Ethnicity: _____ Handedness: Left / Right

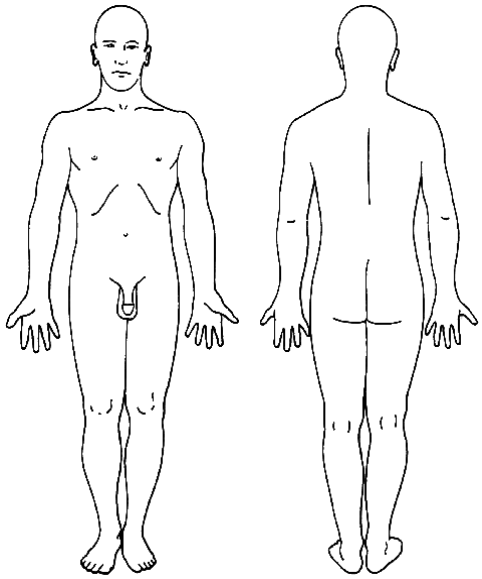
Occupation: _____ Is this a work Related Injury? Yes No

Leisure Activities: _____

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

Are you latex sensitive (allergic to latex)? YES NO List any other allergies we should know about: _____

Please mark all of the locations on the body diagram where you have pain or other symptoms with an X and indicate all of the areas that you do not have any pain or other symptoms with an O.



For Office Use

Please check (✓) any of the following whose care you're under

____ Medical Doctor (M.D.)
____ Osteopathic Doctor (D.O.)
____ Dentist
____ Psychiatrist/Psychologist
____ Physical Therapist
____ Chiropractor
____ Athletic Trainer
____ Nurse Practitioner
____ Physician Assistant
____ Other: _____

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

_____

Please describe any diagnostic testing (Blood work, x-rays, MRI etc.) that has been done during the past three months including the approximate date and reason for the test:

DATE	TEST	DATE	TEST
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT NAME: _____

Have **YOU** ever been diagnosed as having any of the following conditions?

Cancer	YES	NO
If YES, describe what kind: _____		
Heart problems	YES	NO
High blood pressure	YES	NO
Asthma/Emphysema	YES	NO
Chemical dependency (i.e. –alcoholism)	YES	NO
Thyroid problems	YES	NO
Diabetes	YES	NO
Multiple sclerosis	YES	NO
Rheumatoid arthritis	YES	NO
Osteoarthritis	YES	NO
Depression	YES	NO
Hepatitis	YES	NO
Tuberculosis	YES	NO
Stroke	YES	NO
Kidney disease	YES	NO
Anemia	YES	NO
Epilepsy	YES	NO
Headaches	YES	NO
Other	YES	NO

For Office Use

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

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

DATE	REASON	DATE	REASON
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

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

Aspirin	YES	NO	Antacids (i.e. – Tums, Rolaids)	YES	NO
Tylenol	YES	NO	Zantac/ Prilosec/ Pepsid AC	YES	NO
Advil/ Motrin/ Ibuprofen/ Aleve	YES	NO	Vitamins/Mineral supplements	YES	NO
Laxatives	YES	NO	Herbal Medicines	YES	NO
Decongestants	YES	NO	Other: _____		
Antihistamines	YES	NO			

For Office Use

PATIENT NAME:_____

Please circle any of the following that are new, unusual or atypical for you

Weight loss	YES	NO	Recently fallen down	YES	NO
Weight gain	YES	NO	Joint, muscle swelling	YES	NO
Nausea, vomiting	YES	NO	Easy bruising	YES	NO
Dizziness, lightheadedness	YES	NO	Excessive bleeding	YES	NO
Fatigue	YES	NO	Difficulty breathing	YES	NO
Weakness	YES	NO	Regular cough	YES	NO
Fever, chills, sweats	YES	NO	Arm, leg swelling	YES	NO
Numbness or tingling	YES	NO	Heart racing in your chest	YES	NO
Tremors	YES	NO	Difficulty swallowing	YES	NO
Seizures	YES	NO	Heartburn, indigestion	YES	NO
Double vision	YES	NO	Constipation, diarrhea	YES	NO
Loss of vision	YES	NO	Blood in stools	YES	NO
Eye redness	YES	NO	Problems urinating	YES	NO
Skin rash	YES	NO	Urinary incontinence	YES	NO
Problems sleeping	YES	NO	Blood in urine	YES	NO
Sexual difficulties	YES	NO	Stress at home or work	YES	NO
Night sweats	YES	NO	Problems with balance	YES	NO
Hearing problems	YES	NO			

For Office Use

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

Cancer	YES	NO
If YES, describe what kind: _____		
Heart problems	YES	NO
High blood pressure	YES	NO
Asthma/Emphysema	YES	NO
Chemical dependency (i.e. –alcoholism)	YES	NO
Thyroid problems	YES	NO
Diabetes	YES	NO
Multiple sclerosis	YES	NO
Rheumatoid arthritis	YES	NO
Osteoarthritis	YES	NO
Depression	YES	NO
Hepatitis	YES	NO
Tuberculosis	YES	NO
Stroke	YES	NO
Kidney disease	YES	NO
Anemia	YES	NO
Epilepsy	YES	NO
Headaches	YES	NO
Other	YES	NO

For Office Use

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

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

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 drink alcohol? _____

How many days do you use marijuana or other drugs? _____

_____ _____

Therapist Signature Date Patient Signature Date

PATIENT NAME:_____