

Patient Medical History



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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: _____

Leisure Activities: _____

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

Are you latex sensitive? Yes No List any 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 _____
 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. If YES, Pacemaker: YES NO
- 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 Other

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During the past month, have you felt down, depressed, or hopeless? Yes No

During the past month, have you had little interest or pleasure in doing things? Yes No

FOR WOMEN: Are you currently pregnant or think you may be? 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. _____	_____

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

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

Has anyone in your immediate family (parents, brothers, 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	Mental illness
YES	NO	Alcoholism (chemical dependency)			

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 _____

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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? _____

Have you recently noted:

YES	NO	weight loss/gain
YES	NO	nausea/vomiting
YES	NO	dizziness/lightheadedness
YES	NO	fatigue/weakness
YES	NO	sleeping problems/night pains
YES	NO	fever/chills/sweats
YES	NO	numbness or tingling

For Office Use

Patient's Signature

Date

Therapist signature

Date