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:

DATE	REASON FOR SURGERY/HOSPITALIZATION
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:

DATE	INJURY	DATE	INJURY
_____________	___________________________	______________	____________________________
_____________	___________________________	______________	____________________________

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

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Patient's Signature Date ______________ Therapist signature Date