

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, your therapist will assist you. Thank you.

NAME: \_\_\_\_\_ DATE OF  
BIRTH: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ LEISURE  
ACTIVITIES: \_\_\_\_\_  
PHONE # (work/daytime): \_\_\_\_\_  
\_\_\_\_\_

Are you currently seeing any of the following?

YES	NO	Medical Doctor	YES	NO	Physical Therapist
YES	NO	Psychiatrist/Psychologist	YES	NO	Dentist
YES	NO	Osteopath	YES	NO	Chiropractor

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

Why are you seeking therapy services?  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any diagnostic tests for this problem (X-Ray, MRI, CT scan, EMG study)?

When: \_\_\_\_\_ Where: \_\_\_\_\_ What were the results?  
\_\_\_\_\_  
\_\_\_\_\_

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	Circulation problems
YES	NO	High blood pressure
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

**For office use**

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

<u>DATE</u>	<u>SURGERY/HOSPITALIZATION</u>	<u>REASON</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the

approximate date of injury:

DATE INJURY

DATE INJURY

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Has anyone in your family EVER been diagnosed as having any of the following conditions? YES NO Diabetes

YES NO Tuberculosis  
YES NO Heart disease  
YES NO High blood pressure  
YES NO Stroke  
YES NO Kidney disease  
YES NO Cancer  
YES NO Arthritis  
YES NO Anemia  
YES NO Headaches  
YES NO Epilepsy  
YES NO Mental illness  
YES NO Chemical dependency (i.e. alcoholism)

**For office use**

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 \_\_\_\_\_

**For office use**

Please list any PRESCRIPTION medications you are currently taking (INCLUDING pills, injectables, and/or skin patches):

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How much caffeinated coffee or caffeine containing beverages do you drink per day? \_\_\_\_\_

How many packs of cigarettes do you smoke per day? \_\_\_\_\_

How many days per week do you drink alcohol? \_\_\_\_\_

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? \_\_\_\_\_

How many days per week do you use marijuana? \_\_\_\_\_

How many days per week do you use drugs such as cocaine, crack, acid, etc.? \_\_\_\_\_

Are you pregnant?

In the past week, have you felt depressed or down? \_\_\_\_\_

In the past week, have you had problems falling asleep or staying asleep? \_\_\_\_\_

How do you best learn?

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Have you recently noted:

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

**For office use**

Form reviewed with patient? YES \_\_\_\_\_ NO \_\_\_\_\_

Therapist

Signature \_\_\_\_\_ Date \_\_\_\_\_

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