Name: ________________________________

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!

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

			Date first Diagnosed				Date first diagnosed
YES	NO	Pacemaker		YES	NO	Multiple Sclerosis	
YES	NO	Cancer. If YES, describe what kind: ____________________________		YES	NO	Rheumatoid Arthritis	
				YES	NO	Other Arthritic Conditions	
YES	NO	Heart Problems		YES	NO	Depression	
YES	NO	High Blood Pressure		YES	NO	Hepatitis	
YES	NO	Circulation Problems		YES	NO	Tuberculosis	
YES	NO	Asthma		YES	NO	Stroke	
YES	NO	Emphysema/Bronchitis		YES	NO	Kidney Disease	
YES	NO	Chemical Dependency (i.e. Alcoholism)		YES	NO	Anemia	
YES	NO	Thyroid Problems		YES	NO	Epilepsy	
YES	NO	Diabetes		YES	NO	Osteoporosis/Osteopenia	
				YES	NO	Other: ______________________	

YES NO 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 FOR WOMEN ONLY: Are you currently pregnant or think you might be pregnant?

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. _______ ____
5. _______ ____ 6. _______ ____

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:

_________ ____ _________ ____

_________ ____ _________ ____

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

YES	NO	Aspirin	YES	NO	Antihistamines
YES	NO	Tylenol/Acetaminophen	YES	NO	Antacid
YES	NO	Advil/Motrin/Ibuprofen	YES	NO	Vitamins/Mineral Supplements
YES	NO	Laxatives	YES	NO	Other: ______________________________
YES	NO	Decongestants			

Please list any medication you are currently taking, including over the counter, herbals, and vitamin supplements. Please indicate the route (example: oral, injection, skin patch, etc.) Also include dosage and frequency. Use back side if more room is needed.

1. _______________________________ 2. _______________________________ 3. _______________________________
4. _______________________________ 5. _______________________________ 6. _______________________________

Steroid Use? E.g. Inhalers, Injections, Oral Steroids

1. _______________________________ 2. _______________________________ 3. _______________________________

Have you had a diagnostic testing? (X-Ray, MRI, Bone Density) Include dates.

YES NO ___________________________ Where?______________________ Date: ______________________

Have you recently noted:

YES	NO	Weight Loss/Gain	YES	NO	Weakness
YES	NO	Nausea/Vomiting	YES	NO	Fever/Chills/Sweats
YES	NO	Fatigue	YES	NO	Numbness or Tingling

____ ______________________________

Patient Signature **Date**