Welcome! In order to help the therapist evaluate you properly, we need to collect some information. Please fill out both pages. If you are not sure, leave it blank as the therapist will be reviewing the information with you during your evaluation.

Name: ______________________________ DOB______________ Age: ______Marital Status: M S W D
Occupation:___________________________________ Currently working? YES NO LIGHT DUTY
Hobbies/Sports/Lifestyle: ____
The problem I am here for is: ____
____

Other medical conditions I had in the past or currently have are: CIRCLE YES OR NO

Cancer	YES NO	Diabetes	YES NO
Breathing Problems	YES NO	Stroke	YES NO
High Blood Pressure	YES NO	Circulation Problems	YES NO
Heart Problems	YES NO	Stomach Ulcers	YES NO
Depression	YES NO	Drug/Alcoholism	YES NO
Thyroid Disease	YES NO	Fibromyalgia	YES NO
Rheumatoid Arthritis	YES NO	Osteoarthritis	YES NO
Herniated Disc	YES NO	Multiple Sclerosis	YES NO
Diseases of the Brain	YES NO	Diseases of the Nerves	YES NO
Peripheral Neuropathy	YES NO	History of Falling	YES NO
Pneumonia	YES NO	Tuberculosis	YES NO
Blood disorders	YES NO	Anemia	YES NO
Kidney disease	YES NO	Osteoporosis	YES NO
Joint Sprains	YES NO	Broken bones	YES NO
Pregnant	YES NO MAYBE	Post Menopause	Yes NO
Seizure	YES NO	Pacemaker	YES NO

Surgeries or major hospitalizations I have had- Date and Reason/Surgery:
1.________________________________ 2. ____________________________________

3. ________________________________ 4. ____________________________________

I am allergic to:
Medications: **Latex allergy? YES NO**
____
Food: ____
Other: ____

Have any of your parents or siblings had any of the following problems: CIRCLE YES OR NO

Cancer	YES NO	Diabetes	YES NO
Heart Problems	YES NO	Stroke	YES NO
High Blood Pressure	YES NO	Depression	YES NO
Drug/Alcoholism	YES NO	Kidney Disease	YES NO
Rheumatoid Arthritis	YES NO	Ankylosing Arthritis	YES NO

Therapist's notes:

Do you smoke cigarettes? YES NO ___ packs/day x ____ years; **I quit:** _______________
Do you chew tobacco? YES NO # ______Hrs per day x ______years; **I quit:** _______________

# of Caffeinated drinks per day: _________
# of Alcoholic drinks per weekday: _______ ; per weekend day:___________

List **all** medications you **are currently taking** including over the counter, vitamins, patches, herbals and any medication, **whether prescribed or not prescribed** by a physician over the last week:

1. ________________	2. ____________________	3. _____________________
4. ________________	5. ____________________	6. _____________________
7. ________________	8. ____________________	9. _____________________
10. ________________	11. ____________________	12. _____________________

Please circle any of the following if you have taken them in the last week:
Aspirin Ibuprofen Advil Aleve Motrin Naprosen/Naproxen Tylenol

Therapist's notes:

Name any medical practitioners you have seen in the last 6 months including physicians, chiropractors, physical therapists, and mental health professionals:

Name: ______________________________ Specialty: ________________________________
Name: ______________________________ Specialty: ________________________________
Name: ______________________________ Specialty: ________________________________

CIRCLE YES OR NO. Indicate YES for any complaint that is NEW or CHANGED recently:

Weight/loss gain	YES NO	Heart racing	YES NO
Change in vision	YES NO	Shortness of Breath	YES NO
Change in hearing	YES NO	Cough not from cold	YES NO
Dizziness	YES NO	Pain not relieved by rest	YES NO
Lightheadedness	YES NO	Stiffness not relieved by moving	YES NO
Vertigo	YES NO	Pain worse during sleep	YES NO
Heart palpitations	YES NO	Increased stress	YES NO
Insomnia	YES NO	Night sweats	YES NO
Fevers/chills	YES NO	Redness in eye	YES NO
Bruise/bleeding	YES NO	Numbness/Tingling/Burning	YES NO
Swelling	YES NO	Urinary incontinence	YES NO
Swallowing difficulty	YES NO	Difficulty starting urinating/pain	YES NO
Blood in Urine/stool	YES NO	Constipation/Diarrhea	YES NO
Weakness/fatigue	YES NO	Nausea/Vomiting	YES NO
Tremors	YES NO	Rashes or open sores	YES NO
Deep aching pain	YES NO	Sexual difficulties	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 (1)

Therapist's notes:

NO SHOW/CANCELLATION POLICY

We do not charge for no show appointments, but we do set aside (1) hour of treatment time for your therapy. If there are more than (3) no shows/cancellations, you will be required to see your physician before returning for treatment.

If you are going to cancel, please notify us within 24 hours of your scheduled appointment.

If you are later than 20 minutes for an appointment you will need to reschedule.

Please keep in mind that any missed appointments will jeopardize your therapy regimen.

____

Signature/Date