

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: \_\_\_\_\_

LEISURE ACTIVITIES: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_  
Are you latex sensitive? YES NO

**Please circle if you have EVER been diagnosed with any of the following conditions:**

- |                                       |                            |                |
|---------------------------------------|----------------------------|----------------|
| Cancer _____                          | Thyroid Problems           | Tuberculosis   |
| Heart Problems                        | Diabetes                   | Stroke         |
| High Blood Pressure                   | Multiple Sclerosis         | Kidney Disease |
| Circulation Problems                  | Rheumatoid Arthritis       | Anemia         |
| Asthma                                | Other Arthritic Conditions | Epilepsy       |
| Emphysema/Bronchitis                  | Depression                 | Other _____    |
| Chemical Dependency (i.e. alcoholism) |                            |                |

**Have you recently noted:**

- |                      |  |
|----------------------|--|
| Weight Gain          |  |
| Nausea/Vomiting      | During the past month have you been feeling down, depressed or hopeless? YES NO        |
| Fatigue              | During the past month have you had little interest or pleasure in doing things? YES NO |
| Weakness             | Do you ever feel unsafe at home or has anyone hit you or tried to injure you           |
| Fever/Chills/Sweats  | in any way? YES NO   |
| Numbness or Tingling | FOR WOMEN: Are you currently pregnant or thing you might be pregnant? 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:

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

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Please list any or provide a sheet of **prescription medications** you are currently taking (pills, injections, and/or skin patches):

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\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date