To be filled out by the patient or caregiver. **Name:** _____

Current Health and Past History: **Date of Birth:** _____

List significant medical diagnoses and conditions: _____

_____

Check the box if you've had any of the following:

_____diabetes
_____rheumatic fever
_____heart murmur
_____high blood pressure
_____low blood pressure
_____heart disease
_____varicose veins
_____circulatory problems
_____dyspnea/ shortness of breath
_____lung disease
_____epilepsy/seizures
_____cancer (what type)
_____sight or hearing impaired
_____skin allergies/infection/open wounds
_____thrombophlebitis
_____arthritis
_____migraine headaches
_____syncope/fainting spells
_____bowel/bladder dysfunction
_____multiple sclerosis
_____pacemaker
_____neurological problems- numbness, weakness, tremors
_____stroke
_____broken bones (fracture)
_____kidney or liver disease
_____AIDS/HIV
_____metal implants
_____tuberculosis
_____anemia
_____infectious disease
_____Other

List prior surgeries or hospitalizations and dates: _____

_____

List medications you are presently on (include all prescription and non-prescription medications and herbal products): _____

_____

Are you allergic to any medications? _____ NO _____ YES If so, list medications and the type of reaction you had: (for example- Penicillin causes rash): _____

_____

Any other allergies (examples- latex, food, dyes, contrasts): _____ NO _____ YES_____

Females: Is there a chance you may be pregnant at this time? _____ NO _____ YES

Have you had any falls in the last 12 months? _____ NO _____ YES If yes, how many?_____

Continue on to back...

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Pain: Do you have pain? _____ NO _____ YES (If yes, then complete the remaining portion of this section.)

Where does it hurt? _____

Describe how the pain "feels" - stabbing, burning, gnawing, sharp, dull, radiating, etc.

_____

Describe how long you've experienced pain, how long it lasts: _____

How would you rate your pain at this moment? (please circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Possible Pain

How are you managing your pain? Heat, Cold, positioning, medications, other: _____

_____

Activity
Do you engage in regular exercise? _____ NO _____ YES If yes, what type and how often?_____

_____

Do you have shortness of breath? _____ NO _____ YES

What is your occupation?_____

Is your occupation _____ active _____ inactive _____ heavy work?

In general, your lifestyle is (please circle): **1 2 3 4 5**
Inactive Average Active

Substance Use

Substance	Type	How Much	None	Comments
Caffeine				
Tobacco				
Alcohol				

Reason for Treatment
How did your condition/injury occur?_____
Date of injury/onset_____
Have you ever received any other treatment for this condition? _____
What are your goals for therapy?

_____

Who may we thank for your referral?_____

Person completing the form: Signature_____**Date**_____

Therapist Signature_____**Date**_____ **Time**_____