Evaluation Date _____

Name _____
DOB _____
Doctor _____
Medical Record # _____

Please identify the reason for your visit: _____

_____

When did your current condition begin? _____

What originally caused your current symptoms?

_____ Not sure how it started
_____ Motor vehicle accident
_____ Cough/sneeze
_____ Fall/Slip
_____ Bend/twist
_____ Lifting
_____ Yard work
_____ Sports activity
_____ Shoveling
_____ Other: _____

Have you **EVER** been diagnosed as having the following conditions?

_____ Heart problems
_____ High blood pressure
_____ Circulation problems
_____ Asthma
_____ Emphysema/bronchitis
_____ Chemical dependency
_____ Thyroid problems
_____ Diabetes
_____ Multiple sclerosis
_____ Rheumatoid arthritis
_____ Other arthritic conditions
_____ Depression
_____ Hepatitis
_____ Tuberculosis
_____ Stroke
_____ Kidney problems
_____ Anemia
_____ Epilepsy/seizures
_____ Cancer -- If Yes, what kind: _____
_____ Other: _____

For Women:
Are you or could you be pregnant?
Yes **No**
(Circle One)

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

	Date	**Reason**		**Date**	**Reason**
1	_____	_____	4	_____	_____
2	_____	_____	5	_____	_____
3	_____	_____	6	_____	_____

ALLERGIES:

List any medications you are allergic to: _____
List any allergies you know about: _____
Are you latex sensitive? _____ Yes _____ No

Which of the following **over-the-counter** medications have you taken in the last week?

_____ Advil/Motrin/Ibuprofen
_____ Antihistamines
_____ Antacids
_____ Aspirin
_____ Decongestants
_____ Vitamins/Mineral Supplements
_____ Laxatives
_____ Tylenol

Other: _____

Please list any prescription medications you are currently taking (including pills, injections, patches).

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Do you require accommodation for: **(please circle)** Language Learning Needs Cultural Needs Physical Needs Emotional Needs

Therapist _____ Date _____