To ensure that 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: _____ Right or Left Handed:_____

HAVE YOU RECEIVED ANY TYPE OF HOME HEALTH SERVICES IN THE PAST 3 MONTHS? _____

Allergies: List any medications you are allergic to:_____
_____

Are you latex sensitive? Yes No List any other allergies we should know:_____

Please check any of the following whose care you are currently under:

_____Medical Doctor (MD)	_____Psychiatrist/Psychologist	Other:_____
_____Osteopath	_____Physical Therapist	_____
_____Dentist	_____Chiropractor	

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):
_____

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

Yes	No	Cancer. If YES, describe what kind_____
Yes	No	Heart problems
Yes	No	High blood pressure
Yes	No	Circulation problems
Yes	No	Asthma
Yes	No	Emphysema/Bronchitis
Yes	No	Chemical dependency (i.e. alcoholism)
Yes	No	Thyroid problems
Yes	No	Diabetes
Yes	No	Multiple sclerosis
Yes	No	Rheumatoid arthritis
Yes	No	Other arthritic conditions
Yes	No	Depression
Yes	No	Hepatitis
Yes	No	Tuberculosis
Yes	No	Stroke
Yes	No	Kidney Disease
Yes	No	Anemia
Yes	No	Epilepsy
Yes	No	Anxiety Disorder
Yes	No	Other

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

Please list any surgeries or significant injuries for which you have been treated in the past, including the approximate date and outcome:

DATE	Injury or Surgery		
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

How many times have you fallen in the past year? _____

Did any of those falls result in an injury? _____

RATE YOUR PAIN TODAY ON A SCALE FROM 0 TO 10 ON THE LINE BELOW

0 (NO PAIN) _____ 10 (UNBEARABLE PAIN)

How many packs of cigarettes do you smoke per day? _____

Have you recently noted:

Yes	No	Weight loss/gain
Yes	No	nausea/vomiting
Yes	No	fatigue
Yes	No	weakness
Yes	No	fever/chills/sweats
Yes	No	numbness or tingling

List 3 FUNCTIONAL ACTIVITIES that are limited or you can no longer perform because of your pain:

1._____

2._____

3._____

_____ _____ _____

Patient signature Date

_____ _____

Therapist signature Date