THIS SURVEY WILL HELP US TO ESTABLISH AN APPROPRIATE EVALUATION AND TREATMENT PROGRAM FOR YOU. ANY INFORMATION WILL BE CONSIDERED WITH THE STRICTEST CONFIDENCE AND WILL BE PART OF YOUR MEDICAL RECORD.

Name: _____ Occupation: _____

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? YES NO

List any other allergies we should know about: _____

Do you have an advanced medical directive? YES NO

(If yes, please bring in a copy for your record)

Please check (✓) any of the following whose care you are 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	Rheumatoid arthritis
YES	NO	Heart Problems	YES	NO	Arthritis
YES	NO	Heart Attack/Angina	YES	NO	Total Joint Replacement
YES	NO	Pacemaker	YES	NO	Osteoporosis
YES	NO	High blood pressure	YES	NO	Depression
YES	NO	Circulation problems	YES	NO	Hepatitis
YES	NO	Asthma	YES	NO	Tuberculosis
YES	NO	Emphysema/Bronchitis/COPD	YES	NO	Stroke
YES	NO	Chemical Dependency (alcohol/drugs)	YES	NO	Kidney Disease
YES	NO	Thyroid Problems	YES	NO	Liver Disease
YES	NO	Diabetes	YES	NO	Anemia
YES	NO	Multiple Sclerosis	YES	NO	Epilepsy
YES	NO	Dialysis	YES	NO	Metal Implants
YES	NO	Dizziness	YES	NO	Amputations
YES	NO	Prostate problems	YES	NO	Other
YES	NO	Loss of Sensation			

Therapist's Notes:

Have you had any diagnostic tests for this problem? (x-ray, MRI, etc) _____

Do you ever feel unsafe at home or has anyone tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Do you smoke? YES NO How much per day? _____

If we are treating you post-surgery, may we access your surgical record? YES NO

Do you require assistance with normal activities? YES NO

If YES, who provides this assistance? _____

Have you had any falls within the past year? YES NO If yes, how many? _____ Were you injured? YES NO

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Please list any surgeries, conditions for which you have been hospitalized, including the approximate date and reason:

Date / Reason for hospitalization

Please describe any significant injuries for which you have been treated fractures, sprains, dislocations and the approximate date of the injury.

Date / Injury

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Aspirin	YES	NO
Tylenol	YES	NO
Advil/Motrin/ Ibuprofen	YES	NO
Laxatives	YES	NO
Decongestants	YES	NO
Antihistamines	YES	NO
Antacid	YES	NO
Vitamins/mineral supplements	YES	NO
Other	YES	NO

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or skin patches)

1 2 3

4 5 6

Have you recently noted:

Weight loss/gain	YES	NO
Nausea/vomiting	YES	NO
Fatigue	YES	NO
Weakness	YES	NO
Fever/chills/sweats	YES	NO
Numbness or tingling	YES	NO
Pain	YES	NO

I learn best by: _____Pictures _____Reading _____Listening _____Demonstration

Please use the Managing Pain Pamphlet that you received with your registration and describe and rate your pain on a scale of 0-10.

My current pain level is:_____ I would describe may pain as _____

My goals in therapy are:

1_____

2_____

3_____

Therapist's Notes:

Therapist's Signature_____ Printed Name _____ Date_____ Time _____

Patient's Signature _____ Date _____ Time _____

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