****

**Health Background Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_­\_

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

\_\_Physician (MD, OD) \_\_Surgeon \_\_Dentist \_\_Psychiatrist/Psychologist \_\_Physical Therapist

\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have ever been diagnosed with any of the following conditions?

YES NO Cancer. If yes, what kind:

YES NO High blood pressure

YES NO Heart Problems. If yes, what kind:

YES NO Circulation Problems

YES NO Stroke

YES NO Diabetes

YES NO Thyroid problems

YES NO Asthma

YES NO Emphysema/Bronchitis

YES NO Chemical dependency (eg alcoholism)

YES NO Depression

YES NO Rheumatoid arthritis

YES NO Other arthritis conditions

YES NO Blood clots

YES NO Osteoporosis/osteopenia

YES NO Kidney disease

YES NO Allergies. If yes, list\_\_\_\_\_\_\_\_\_\_\_

YES NO Hepatitis

YES NO Tuberculosis

YES NO Neurological problems ( eg MS, Parkinson’s )

YES NO Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgeries and hospitalizations for other conditions

1. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for any fractures, dislocations, sprains or other significant injuries? If yes, please indicate date and injury below:

1. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you felt little interest or pleasure in doing things? YES NO

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

Are you currently pregnant, or think you might be? YES NO

Please mark any of the following that are **NEW** or **UNUSUAL** for you:

YES NO Weight Loss/gain

YES NO Fatigue

YES NO Weakness

YES NO Joint/muscle swelling

YES NO Leg/arm swelling

YES NO Numbness/tingling

YES NO Dizziness/lightheadedness

YES NO Nausea/vomiting

YES NO Fever/chills/sweats

YES NO Excessive bleeding/bruising

YES NO Constipation/diarrhea

YES NO Change in urination

YES NO Change in vision

YES NO Difficulty breathing

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

YES NO Aspirin

YES NO Anti-inflammatories

YES NO Tylenol

YES NO Heartburn/ulcer medication

YES NO Vitamin/mineral supplements

YES NO Other medications/supplements

Please list all medications below:  
  
1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days a week do you exercise? \_\_\_\_\_\_\_\_\_

How many cups of coffee or other caffeinated beverages do you drink per day? \_\_\_\_\_\_\_\_\_

How many cigarettes do you smoke per day? \_\_\_\_ For how many years? \_\_\_\_ If you quit, when? \_\_\_\_\_\_\_\_\_\_

How many days per week do you drink alcohol? \_\_\_\_\_\_\_\_\_

If one drink equals one beer, one glass of wine, or one ounce of hard liquor, how many do you drink per average sitting? \_\_\_\_\_\_\_\_\_

Have any of your immediate family members (parents, brothers, sisters) been treated for any of the conditions below?

YES NO Diabetes

YES NO Cancer

YES NO High blood pressure

YES NO Arthritis

YES NO Heart problems

YES NO Depression

YES NO Kidney disease

YES NO Stroke

YES NO Chemical dependence

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_