MEDICAL HISTORY INTAKE FORM

Name____Age____________

Height________________Weight____________________   ______________

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

Latex Sensitivity Yes No

Allergies: Yes No If yes, to what:____________________________

Cancer Yes No If yes, what kind:__________________________

Heart problems	Yes No		Chemical dependency (e.g. alcoholism)	Yes No	
High Blood Pressure	Yes No		Multiple sclerosis	Yes No	
Osteoporosis	Yes No		Rheumatoid arthritis	Yes No	
Urinary Incontinence	Yes No		Circulation problems	Yes No	
Depression	Yes No		Asthma	Yes No	
Hepatitis	Yes No		Emphysema	Yes No	
Tuberculosis	Yes No		Bronchitis	Yes No	
High Cholesterol	Yes No		Epilepsy/Seizures	Yes No	
Stroke	Yes No		Thyroid problems	Yes No	
Kidney Disease	Yes No				

Diabetes Yes No If yes, do you have **Type I** or **Type II** (please circle)

Osteoarthritis Yes No If yes, what area? ____________________________

Other illnesses diagnosed by a physician___________________________________

Do you ever feel unsafe at home or has anyone tried to hurt you in any way? Yes No

For women: Are you currently pregnant or do you think you might be pregnant? Yes No

Please list any surgeries or other conditions for which you have been hospitalized, and the approximate date of the hospitalization: ____
____

Please list any injuries, like fractures or sprains, for which you have been treated, and the approximate date of the injury ____
____

Please circle the conditions listed below for which your immediate family has been treated:

Diabetes Stroke Kidney disease Alcoholism Tuberculosis Cancer

Arthritis Anemia Heart disease Headaches Epilepsy Mental Illness

High Blood Pressure Osteoporosis Other:__________________________________

Please circle any OVER-THE-COUNTER medications you have taken in the past week, if any:

Aspirin Ibuprofen (ex: Advil/Motrin) Aleve Acetaminophen (ex: Tylenol)

Antacids (Tums, Zantac, Pepcid) Decongestants Antihistamines Vitamins/Supplements

Other:_________________________

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

Have you recently noted:

Weight Loss/Gain Yes No Fatigue/Weakness Yes No Dizziness/Light-headedness Yes No

Fever/Chills/Sweats Yes No Nausea/Vomiting Yes No Numbness/Tingling Yes No

________________________________ ________________________________
Patient Signature Date Therapist Signature Date