

MEDICAL HISTORY INTAKE FORM

Name _____ Age _____

Occupation: _____ Highest Educational Level: _____

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 | Osteoarthritis | 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, were you diagnosed before age 18? | Yes | No |

Other illnesses diagnosed by a physician _____

During the past month, have you felt down, depressed, or had little interest or less pleasure in doing things? Yes No

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): _____

How many cups of caffeinated beverages (coffee, tea, soda) do you drink a day? _____

Do you smoke? Yes No If yes, how many packs do you smoke a day? _____

Do you drink alcohol? Yes No If yes, how many days per week do you drink? _____
Using a scale of 1 drink = 12 oz. of beer, 5 oz. of wine, or 1 shot of liquor, how many drinks do you drink during an average day? _____

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