

Past Medical History:

LAST TIME YOU CONSIDERED YOURSELF WELL _____

MEDICAL ILLNESSES: _____

INJURIES/ACCIDENTS: _____

OPERATIONS: _____

HOSPITALIZATIONS: _____

CURRENT MEDICATIONS: _____

DRUG ALLERGIES: _____

DO YOU HAVE A HISTORY OF: (circle any that apply)

- | | | |
|----------------|-----------------|---------------------|
| anemia | diabetes | heart disease |
| blood disorder | tuberculosis | lung disease |
| asthma | immune disorder | high blood pressure |
| hay fever | liver disease | cancer |

Review of Systems: (Please circle other symptoms you are currently having)

- | | | | | |
|---------------------------------------|--|---|---------------|-----------------|
| weakness | fatigue | stiffness | clumsiness | imbalance |
| dizziness | weight loss | nausea | vomiting | deafness |
| ringing in ears | blurry vision | loss of vision | double vision | spots in vision |
| change in taste/smell | sweating/flushing | skin changes | rash | bruises |
| restlessness | confusion | irritability | depression | memory loss |
| change in thirst/appetite/elimination | urinary retention/frequency/incontinence | frequent infections | | |
| paralysis | difficulty speaking or swallowing | difficulty comprehending speech/writing | | |

Family History:

mother's age _____ known illnesses _____ cause of death _____

father's age _____ known illnesses _____ cause of death _____

number of sibling's _____ ages _____ known illnesses _____

other family members with similar symptoms to yours _____

Social History:

Live alone? _____ Name of person you live with _____ married __ single __ widowed __

Number of marriages _____ number of children _____ ages of children _____ all living? _____

Number of years in school _____ advanced degrees _____ occupation _____ still working? _____

Military service _____ residence abroad _____

Hobbies _____ recreation _____

alcoholic beverages/day _____ # cigarettes/day _____ other drugs taken _____

cups coffee/day _____ # sodas/day _____ # cups water/day _____ # meals/day _____ # hours exercise/day _____

hours slept/day _____

Treatment goals _____

Functional Abilities:

<u>I can currently...</u>	without difficulty	with some difficulty	with much difficulty	only with assistance
Get in and out of bed	•	•	•	•
Bathe myself	•	•	•	•
Use the toilet	•	•	•	•
Dress myself	•	•	•	•
Cook for myself	•	•	•	•
Feed myself	•	•	•	•
Get in and out of a chair	•	•	•	•
Do simple housework	•	•	•	•
Get in and out of a car	•	•	•	•
Drive within 5 miles of home	•	•	•	•

<u>I am currently able to...</u>	without difficulty	with some difficulty	with much difficulty	unable to do
Sleep restfully	•	•	•	•
Sit for 10 minutes	•	•	•	•
Sit for 30 minutes	•	•	•	•
Sit for 2 hrs or more	•	•	•	•
Stand for 10 minutes	•	•	•	•
Stand for 30 minutes	•	•	•	•
Walk inside the house	•	•	•	•
Walk 2 blocks	•	•	•	•
Walk one mile	•	•	•	•
Walk up two flights of stairs	•	•	•	•
Bend over to pick something up	•	•	•	•
Reach objects overhead	•	•	•	•
Lift objects less than 1 lb.	•	•	•	•
Lift objects weighing 1-10 lbs.	•	•	•	•
Lift objects weighing over 10 lbs.	•	•	•	•
Work my usual job	•	•	•	•
Work modified version of my job	•	•	•	•
Participate in recreation as usual	•	•	•	•
Participate in hobbies as usual	•	•	•	•
Travel as usual	•	•	•	•

I am also currently experiencing:

- Depressed mood •
- Changes in my appetite •
- Agitation •
- Feelings of worthlessness •
- Lack of joy •
- Difficulty sleeping •
- Lack of energy •
- Difficulty thinking or concentrating •
- Change in sexual appetite or function •
- Excessive feelings of fear •

WHO CAN I THANK FOR REFERRING YOU TO THIS PRACTICE? _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____
Name phone

I understand I am financially responsible for any charges incurred. I also authorize the release of any information required to process my insurance claims. For MediCare and other third party payer beneficiaries, I fully understand any or all of these charges may be deemed medically unnecessary by my insurer, and I agree to be responsible for any all charges incurred for claims or parts of claims denied:

Patient or guardian date