CIOFFREDI & ASSOCIATES
THE INSTITUTE FOR HEALTH & HUMAN PERFORMANCE

NAME: _____ DOB: _____ OCCUPATION: _____

FOR OFFICE USE ONLY: Date of initial visit: _____ Case:

Please complete the entire form. If you have a question about an item, please ask your therapist for assistance.

Medical History and Information

Have you declared an Advanced Medical Directive of Do Not Resuscitate (DNR)? YES NO

ALLERGIES: Please list any medications you are allergic to: _____
Are you sensitive to Latex? (circle) YES NO Please list any other allergies: _____

Have you missed any days of work due to your current condition? YES NO **If yes, how many?** ____

Current work status (circle): FULL TIME PART-TIME RESTRICTED
Work duties affected by current condition: _____

Please check all practitioners for which you've sought care for your current condition:

[ ] Medical Doctor (MD) [ ] Osteopath [ ] Dentist [ ] Physical Therapist
[ ] Chiropractor [ ] Massage Therapist: [ ] Other: _____

Have you EVER been DIAGNOSED with any of the following conditions? (circle)

YES NO Cancer. If YES, explain: _____
YES NO Heart/cardiac problems. If YES, explain: _____
YES NO High Blood Pressure
YES NO Peripheral vascular disease, circulation problems
YES NO Asthma
YES NO Rheumatoid Arthritis
YES NO Other arthritic conditions. If YES, explain: _____
YES NO Osteoporosis
YES NO Diabetes
YES NO Thyroid problems
YES NO Multiple Sclerosis
YES NO Kidney disease
YES NO Hepatitis
YES NO Blood clots, DVT
YES NO Depression
YES NO Stroke
YES NO Other: _____
YES NO During the past month, have you been feeling depressed?

For Office Use

Please list any surgeries (including out-patient) or other conditions for which you have been hospitalized (please include the year of surgery/incident): _____
_____
_____

Please list any injuries for which you have been treated including sprains, fractures, dislocations, etc. (please include the year of each incident):
_____
_____

Please list ALL medications you are currently taking and dosage (include pills, patches, injections, non-prescription and vitamins): _____

Adapted from: Boissonnault, W. Primary Care for the Physical Therapist: Examination and Triage 2nd edition. Saunders, 2011.

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Are you currently experiencing, or have you recently experienced any of the following symptoms? (please fill out completely):

YES	NO	Weight loss/gain	YES	NO	Ringing in ears/tinnitus
YES	NO	Nausea/vomiting	YES	NO	Joint/muscle swelling
YES	NO	Dizziness/lightheadedness	YES	NO	Difficulty breathing
YES	NO	Fatigue	YES	NO	Regular cough
YES	NO	Weakness	YES	NO	Arm/leg swelling
YES	NO	Fever/chills/sweats	YES	NO	Difficulty swallowing
YES	NO	Numbness/tingling	YES	NO	Heartburn/indigestion
YES	NO	Tremors	YES	NO	Bowel/Bladder changes
YES	NO	Seizures	YES	NO	Difficulty sleeping
YES	NO	Double vision or loss of vision	YES	NO	Sexual difficulties
YES	NO	Night sweats	YES	NO	Skin rash

Personal rating of overall health (circle one): EXCELLENT GOOD FAIR POOR

Please answer YES or NO for the following, and fill in blanks as appropriate:

YES NO Are you now or could you be pregnant or trying to become pregnant?
YES NO Do you drink caffeinated beverages? How many per day: _____
YES NO Do you use tobacco? Packs per day: _____ Years of use: _____ If quit, when? _____
YES NO Do you drink alcohol? Drinks per day: _____ (one drink = one glass of beer or wine)

Has anyone in your immediate family (parents, siblings) been treated for the following:

YES	NO	Cancer	YES	NO	Diabetes
YES	NO	Heart/cardiac disease	YES	NO	High blood pressure
YES	NO	Stroke	YES	NO	Kidney disease
YES	NO	Inflammatory arthritis (Rheumatoid, Ankylosing)			

What brings you in for evaluation today? _____
_____

What goals do you have for your treatment? _____
_____

How did you hear about Cioffredi & Associates? _____

Please ensure that your medical history information is filled out in its entirety and to the best of your knowledge.

_____ _____
Patient Signature Date Therapist Signature Date

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