Patient Name: _____ **DOB:** _____

Patient Summary List

Are you allergic to latex? (please circle) YES NO

Do you have any known allergies? (drug or other) YES NO **if YES**, please list below:

Allergies or Drug Allergies	Reaction/Symptoms when allergy occurs	For Clinician Use Only If new, initial and date

❑ Check this box if you have brought a listing of your current medications and you will not have to complete the medication list below. Please give your list to our office staff to include in your chart.

Current Medication List (include OTC and herbal)	Dosage	Frequency	For Clinician Use Only		
			New	D/C	Date/Initials

Medical History (check all that apply)

_____	Heart Disease	_____	Diabetes	_____	Weight change of more than 10 lbs recently		
_____	Fibromyalgia	_____	Tuberculosis	_____	High Blood Pressure	_____	Asthma
_____	HIV/AIDS	_____	Arthritis	_____	Visual Impaired	_____	Epilepsy
_____	Depression	_____	Pacemaker	_____	Hearing Impaired	_____	Cancer
_____	Osteoporosis	_____	Thyroid Problems	_____	Latex Allergy	_____	Scoliosis
_____	Ehlers-Danlos synd.	_____	Alcohol Use	_____	Pregnant	_____	Stroke
_____	Multiple Sclerosis (MS)	_____	Other (please explain):	_____	Tobacco Use	_____	Hepatitis

Additional/New Medical History	If new, Clinician Initial/Date	Surgical/Invasive Procedure History	Date of Procedure	If new, Clinician Initial/Date

**** Patient Signature:** _____ **Date:** _____

Therapist signature: _____ **Date:** _____ **Time:** _____