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.

❑ Check this box if you are NOT currently taking any medications.

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)	_____	Tobacco Use	_____	Other (please explain):	_____	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:** _____