Patient Summary List

Patient Name: ______________________________ **DOB:** ____________

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)

_____ Weight change of more than 10 lbs recently

_____ Heart Disease _____ Diabetes _____ High Blood Pressure _____ Asthma

_____ Fibromyalgia _____ Tuberculosis _____ Visual Impaired _____ Epilepsy

_____ HIV/AIDS _____ Arthritis _____ Hearing Impaired _____ Cancer

_____ Depression _____ Pacemaker _____ Latex Allergy _____ Scoliosis

_____ Osteoporosis _____ Thyroid Problems _____ Pregnant _____ Stroke

_____ Ehlers-Danlos synd. _____ Alcohol Use _____ Tobacco Use _____ Hepatitis

_____ Multiple Sclerosis (MS) _____ Other (please explain): ______________________________

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:** ______________