

Healing In Motion, pllc
 Therapy and Wellness Center
 5340 Plymouth Road, Suite 100
 Ann Arbor, MI 48105
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Health and History

To ensure you receive a complete and thorough evaluation, please provide this background information.

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Leisure Activities/ Sports: _____

Are you currently seeing any of the following?

- | | | | |
|--------------------------|-------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | Medical Doctor (MD, DO) | <input type="checkbox"/> | Psychiatrist/Psychologist |
| <input type="checkbox"/> | Osteopath | <input type="checkbox"/> | Physical therapist |
| <input type="checkbox"/> | Dentist | <input type="checkbox"/> | Chiropractor |
| <input type="checkbox"/> | Personal Trainer | <input type="checkbox"/> | Massage Therapist |

If you have seen or been referred to any of the above during the past three months, please describe the reason for the referral. What was the result? _____

Have you ever been diagnosed as having any of the following conditions?

- | YES | NO | Condition | If yes, describe what kind: |
|-----|----|---------------------------------------|-----------------------------|
| | | Cancer | _____ |
| YES | NO | Heart problems | |
| YES | NO | High blood pressure | |
| YES | NO | Asthma | |
| YES | NO | Emphysema/Bronchitis | |
| YES | NO | Chemical dependency (i.e. alcoholism) | |
| YES | NO | Thyroid problems | |
| YES | NO | Diabetes | |
| YES | NO | Multiple sclerosis | |
| YES | NO | Rheumatoid arthritis | |
| YES | NO | Other arthritic conditions | |
| YES | NO | Depression | |
| YES | NO | Hepatitis | |
| YES | NO | Tuberculosis | |
| YES | NO | Stroke | |
| YES | NO | Kidney disease | |
| YES | NO | Anemia | |
| YES | NO | Epilepsy | |
| YES | NO | Incontinence | |

Are you pregnant? YES NO Number of pregnancies: _____ Number of births: _____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and the reason for the surgery or hospitalization: _____

Please describe any injuries for which you have been treated and the approximate date of the injury:

DATE	INJURY	TREATMENT	OUTCOME

Has anyone in your immediate family (parents, brother, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Tuberculosis
YES	NO	Heart disease	YES	NO	High blood pressure
YES	NO	Stroke	YES	NO	Kidney disease
YES	NO	Cancer	YES	NO	Arthritis
YES	NO	Anemia	YES	NO	Headaches
YES	NO	Epilepsy	YES	NO	Mental Illness
YES	NO	Chemical dependency (Alcoholism)			

Which of the Over-the-counter medications have you taken in the last week?

<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Tylenol	<input type="checkbox"/>	Advil/Motrin/Ibuprofen/Alieve
<input type="checkbox"/>	Laxatives	<input type="checkbox"/>	Decongestants	<input type="checkbox"/>	Antihistamines
<input type="checkbox"/>	Antacid	<input type="checkbox"/>	Vitamins/mineral supplements		

Please list any prescription medication you are currently taking (Including pills, injections and skin patches):

_____	_____
_____	_____
_____	_____

How much caffeinated coffee or other drinks with caffeine do you have per day? _____

How many cigarettes do you smoke a day? _____ If none, have you ever smoked? _____

How many days per week do you drink alcohol? _____

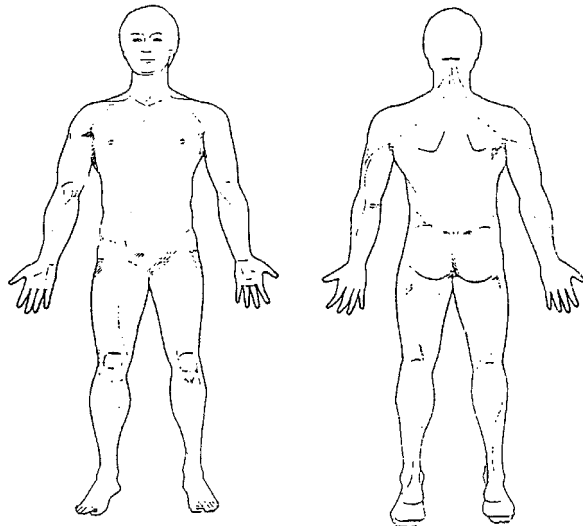
If one drink equals one beer or a glass of wine, how much do you drink at an average sitting? _____

How many days per week do you use recreational drugs (marijuana, cocaine, crack, meth, etc)? _____

Have you recently noted any of the following:

Weight loss or gain?	Weakness
Nausea or vomiting?	Numbness or tingling
Fatigue	

Please indicate on the picture your current feeling of pain, numbness, tingling or any other sensory difficulty:



Patient signature: _____

Date: _____