Asheville Family Fitness & Physical Therapy of Leicester, Inc.
149 New Leicester Hwy, Asheville NC 28806

Please check yes or no for each item.

1. **During the past 3 months have you been seen by any of the following? If yes, please explain why.**
   a. Medical Doctor (MD) ☐ No ☐ Yes ____________________
   b. Chiropractor ☐ No ☐ Yes ____________________
   c. Osteopath ☐ No ☐ Yes ____________________
   d. Dentist ☐ No ☐ Yes ____________________
   e. Psychiatrist/Psychologist ☐ No ☐ Yes ____________________
   f. Physical Therapist ☐ No ☐ Yes ____________________
   g. Massage Therapist ☐ No ☐ Yes ____________________
   h. Acupuncturist ☐ No ☐ Yes ____________________

2. **Have you EVER been diagnosed as having any of the following conditions?**
   a. Cancer ☐ No ☐ Yes
      If yes, what kind?____________________
   b. Rheumatoid Arthritis ☐ No ☐ Yes
   c. Other Arthritic Conditions ☐ No ☐ Yes
      If yes, what kind?____________________
   d. Heart Attack ☐ No ☐ Yes
   e. High Blood Pressure ☐ No ☐ Yes
   f. Asthma ☐ No ☐ Yes
   g. Emphysema/COPD ☐ No ☐ Yes
   h. Dependency: Drugs/Alcohol ☐ No ☐ Yes
   i. Thyroid Problems ☐ No ☐ Yes
   j. Diabetes (Sugar) ☐ No ☐ Yes
   k. Multiple Sclerosis (MS) ☐ No ☐ Yes
   l. Fibromyalgia ☐ No ☐ Yes
   m. Depression/Anxiety ☐ No ☐ Yes
   n. Bi-polar ☐ No ☐ Yes
   o. Hepatitis ☐ No ☐ Yes
   p. Tuberculosis ☐ No ☐ Yes
   q. Stroke ☐ No ☐ Yes
   r. Kidney Disease ☐ No ☐ Yes
   s. Epilepsy/Seizures ☐ No ☐ Yes
   t. Anemia ☐ No ☐ Yes
   u. Post-Polio Syndrome ☐ No ☐ Yes
   v. Osteoporosis ☐ No ☐ Yes
   w. Blood Clot ☐ No ☐ Yes

   Please list any others:____________________

Do you have a pacemaker? ☐ No ☐ Yes

Do you have allergies to any medications? ☐ No ☐ Yes If yes, please list: ____________________

Do you have skin allergies or sensitivities? ☐ No ☐ Yes If yes, please list: ____________________

Please list all surgeries, including year (gallbladder, hysterectomy, knee surgery, etc.)

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____

____

Have you ever had any broken bones? ☐ No ☐ Yes If yes, when & what body part? ____________________

FOR WOMEN: Are you pregnant or possibly pregnant? No Yes If yes, number of months:____________________

Patient Name:____________________ **Date:**____________________

Medications *Please use the next three sections to list all the medications and supplements you have taken in the last week. In the "How do you take this medication" field write pill, injection, under tongue, cream, patch, etc. If you need more space, please use an extra sheet of paper.*

Prescription Medications *(Include birth control pills, injections, skin patches, etc.)*

Name of medication	Dosage	Frequency	How do you take this medication?

Over-the-Counter Medications *(Include decongestants, antacids, sleep aids, antihistamines, laxatives, etc.)*

Name of medication	Dosage	Frequency	How do you take this medication?

Vitamins & Herbal Supplements

Name of supplement	Dosage	Frequency	How do you take this supplement?

11. Check the # of cups of caffeinated coffee, tea or soda you drink per day: ___0 ___1-3 __4-6 ___7-9 ___10+

12. **Do you smoke**? ☐ No ☐ Yes If yes, how many packs per day? ___0-½ ___½-1 ___1-1½ ___1½ -2 ___2+

13. Is there any other medical information about yourself or in your family history that you feel would be helpful to us?

____

____

14. **Living situation**. Please check one: ___Alone ___Spouse ___Family ___Friend ___Institution

15. **Accessibility**, please check all that apply: ___Apartment ___House ___Mobile home ___Ramp ___Rails
___1st floor ___2nd floor ___3rd floor ___1 step ___2 steps ___3+steps ___Other__________________________

16. **Employment Status:** ___Full-time ___Part-time ___Unemployed ___Retired ___Work injury
___Sick leave/disability ___Other:____

X:_______________________________ _______________________________________ _________________
Signature of person completing this form   Printed Name   Date

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Patient Name:____ **Date:**______________________________