

Background Information & Medical History Form: Medicare Beneficiaries Only

To ensure you receive a complete and thorough evaluation, please provide us with the additional information regarding your health status found on this form. If you do not understand a question, leave the area blank and your therapist will assist you. Thank you!

Name (Please Print): _____ Date: _____

Height (Feet and Inches); _____

Weight (Pounds): _____

Office Use Only: BMI: _____

List of all current medications with dosages:
(Includes prescription, over-the-counter, herbals, and vitamin / mineral / dietary supplements):

Name of Medication (Vitamin / mineral / dietary supplement)	Dosage / Frequency
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____

Initial Evaluation:
Form reviewed with patient: YES NO Therapist signature: _____ Date: _____

Re-Evaluation
Form reviewed with patient: YES NO Therapist signature: _____ Date: _____

Re-Evaluation:
Form reviewed with patient: YES NO Therapist signature: _____ Date: _____

Re-Evaluation:
Form reviewed with patient: YES NO Therapist signature: _____ Date: _____

Re-Evaluation:
Form reviewed with patient: YES NO Therapist signature: _____ Date: _____