

Medical History

Check all that apply to you:

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gland Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anxiety /Stress | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Loss of bowel/bladder control |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Other: _____ |

Surgeries	Type	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications _____

Pain (at best) (0= no pain) 0 1 2 3 4 5 6 7 8 9 10 (10= worst possible)
(at worst) (0= no pain) 0 1 2 3 4 5 6 7 8 9 10 (10= worst possible)

Please circle the activities you are having difficulty with because of your complaint

- | | | |
|------------------------|----------|--|
| Sitting | Jumping | Choose 3 activities from the list that you would most like to be able to do without any difficulty:
1 _____
2 _____
3 _____ |
| Squatting | Running | |
| Bending/stooping | Pushing | |
| Walking-short distance | Pulling | |
| Walking- long distance | Reaching | |
| Climbing stairs | Grasping | |
| Lifting | Carrying | |

Thinking about all of the activities you would like to do, mark an “X” on the line that best describes your overall level of difficulty with these activities today.

*** _____ ***

I have extreme difficulty doing any activities I would like to do

I have no difficulty doing any activities I would like to do