



NAME : _____

DATE : _____

Circle YES or NO...

Have you ever been told you have:

- Cancer ? Yes.....No
- Diabetes ? Yes.....No
- High blood pressure ? Yes.....No
- Heart disease ? Yes.....No
- Angina/chest pain ? Yes.....No
- Stroke ? Yes.....No
- Osteoporosis ? Yes.....No
- Osteoarthritis ? Yes.....No
- Rheumatoid arthritis ? Yes.....No

In the past 3 months have you had or do you experience:

- A change in your health ? Yes No
- Nausea/Vomiting ? Yes No
- Fever/chills/sweats ? Yes No
- Unexplained weight change ? Yes No
- Numbness or tingling ? Yes No
- Changes in appetite ? Yes No
- Difficulty swallowing ? Yes No
- Changes in bowel or bladder function ? Yes No
- Shortness of breath ? Yes ... No
- Dizziness ? Yes No
- Upper respiratory infection ? Yes No
- Urinary tract infection ? Yes No

Circle YES or NO...

Do you have a history of:

- Asthma ? YesNo
 - Headaches ? YesNo
 - Bronchitis ? YesNo
 - Kidney disease ? YesNo
 - Rheumatic fever ? YesNo
 - Ulcers ? YesNo
 - Seizures ? YesNo
 - Latex allergies ? YesNo
 - Medication allergies ? YesNo
- List _____

Are you currently:

- Pregnant ? Yes.....No
- Depressed ? Yes.....No
- Under Stress ? Yes.....No

Are you currently receiving any services to help manage stress and/or depression? YES NO

Are your symptoms: (check one)

- Getting worse The same Improving

How are you able to sleep at night? (check one)

- Fine Moderate difficulty Only with medication

Do you have a problem with ... (check all that apply)

- Hearing Vision
- Speech Communication

Do you or have you in the past smoked tobacco? YES NO

If yes, _____ Packs X _____ Years.

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week.

Are you currently involved in a lawsuit? YES NO

Date of last physical examination _____

List medications currently using: _____

List any past surgeries: _____