

Currently, how much of the time does your condition interfered with your normal work?

- Not at all a little bit Moderately Quite a bit Extremely

Currently, how much of the time does your condition interfered with your social activities?

- Not at all a little bit Moderately Quite a bit Extremely

What type of regular exercise do you perform? None Light Moderate Strenuous

Current Height and Weight? _____ ft _____ in _____ lbs

For each of the conditions listed below, please indicate if you have had the condition in the past, or present:

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/ Tobacco Use
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones			
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/ Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection			Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
			<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip/ Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease
<input type="checkbox"/>	<input type="checkbox"/>	Knee/ Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY
			<input type="checkbox"/>	<input type="checkbox"/>	Ulcer			Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Other Birth Control
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/ Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis				<input type="checkbox"/>	<input type="checkbox"/>	Current Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular In coordination	<input type="checkbox"/>	<input type="checkbox"/>	Tumor			
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	OTHER CONDITIONS
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Explain Below

Please list other conditions and/or explain all conditions if necessary

Please list all prescribed and over the counter medications, and supplements that you are currently taking:

Please list all hospitalizations and surgeries:

Other Comments

Patient Signature _____ Date _____