|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BLOOD PRESSURE** |  | **YES** | **NO** |  | **NEUROLOGIC CONDITIONS** |   | **YES** | **NO** |
| Hypertension |  |  |  |  | Stroke/TIA |  |  |  |
| Low Blood Pressure |  |  |  |  | Numbness/Tingling Sensation |  |  |  |
| Normal Blood Pressure |  |  |  |  | Balance Disorders/Falls |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HEART DISEASE** |  | **YES** | **NO** |  | **OTHER CONDITIONS** |   | **YES** | **NO** |
| Heart Attack |  |  |  |  | Muscular Dystrophy |  |  |  |
| Atherosclerotic Disease |  |  |  |  | Rheumatoid Arthritis/Osteoarthritis |  |  |  |
| Myocardial Infarction |  |  |  |  | Multiple Sclerosis/Parkinson’s |  |  |  |
| Rheumatic Heart Disease |  |  |  |  | Epilepsy |  |  |  |
| Heart Murmur |  |  |  |  | Gout |  |  |  |
|  |  |  |  |  | Fibromyalgia |  |  |  |
| **MUSCLE CONDITION** |   | **YES** | **NO** |  | Diabetes |  |  |  |
| Hand, Wrist, Elbow Pain/Strain |  |  |  |  | Hearing Loss, Poor Eyesight |  |  |  |
| Shoulder Pain/Strain |  |  |  |  | Cancer, Unexplained Weight Loss |  |  |  |
| Back/Neck Pain/Strain |  |  |  |  | Fainting, Nausea, Vomiting, Fatigue |  |  |  |
| Hip/Pelvis, Knee, Foot Pain |  |  |  |  | Polio |  |  |  |
|  |  |  |  |  | Vertigo/Dizziness |   |   |   |
| **LUNGS** |  | **YES** | **NO** |  |  Allergies |   |   |   |
| Asthma  |  |  |  |  | Osteoporosis |   |   |   |
| Shortness of Breath |  |  |  |  |
| Emphysema |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   |   | EXERCISE |   |   |  WORK ACTIVITY |  STRESS LEVEL |   |  | HABITS |  |   |   |
|   |  | None |  |  | Sitting |  |  | Low |  |  | Smoking |  | Packs a day |  |   |
|   |  | 1-2 x week |  |  | Standing |  |  | Medium  |  |  | Alcohol |  | Drinks a week |  |   |
|   |  | 3-4 x week |  |  | Light labor |  |  | High |  |  | Coffee/Soda |  | Cups a week |  |   |
|   |  | 5+ x week |  |  | Heavy labor |  |  |  |  |  |  |  |  |  |   |
|   | What types of exercise do you perform? |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   | What causes stress in your life? |   |   |   |   |   |   |   |   |  |
|  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Are you taking any seizure medication? |   |   | YES |   | NO |   | If yes, list name(s): |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  |  |   |
|  |  | YES |  | NO |  | If yes, list name(s): |   |   |   |   |
|  | List all medications you are currently taking: |  |   |   |   |   |   |   |   |   |
|  |   |   |   |   |   |   |   |   |   |   |   |   |   |
|  | List all surgeries in the past two years (including dates): |  |  |  |   |   |   |   |   |
|  |   |   |   |   |   |   |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Are you pregnant? |  | YES |  | NO |  | What week? |  |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Have you had any injuries related to work? |  | YES |  |  | NO |  | If yes, list body part(s) and date? |   |
|  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|  | Have you had any auto accidents? |  |  | YES |  |  | NO |  If yes, list body part(s) and date? |   |
|  |  |  |  |  |  |  |  |  |  |  |  |
|   | Have you had Physical Therapy or Massage Therapy before? |   |  YES |   |   | NO |  | If yes, where? |   |   |   |