|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BLOOD PRESSURE** |  | **YES** | **NO** |  | **JOINT CONDITIONS** |  | **YES** | **NO** |
| Hypertension |  |  |  |  | Upper Extremity |  |  |  |
| Low Blood Pressure |  |  |  |  | Dislocation |  |  |  |
| Normal Blood Pressure |  |  |  |  | Lower Extremity Dislocation |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HEART DISEASE** |  | **YES** | **NO** |  | **OTHER CONDITIONS** |  | **YES** | **NO** |
| Heart Attack |  |  |  |  | Muscular Dystrophy |  |  |  |
| Atherosclerotic Disease |  |  |  |  | Rheumatoid Arthritis |  |  |  |
| Myocardial Infarction |  |  |  |  | Multiple Sclerosis |  |  |  |
| Rheumatic Heart Disease |  |  |  |  | Epilepsy |  |  |  |
| Heart Murmur |  |  |  |  | Gout |  |  |  |
|  |  |  |  |  | Fibromyalgia |  |  |  |
| **MUSCLE CONDITION** |  | **YES** | **NO** |  | Diabetes |  |  |  |
| Carpal Tunnel R/L |  |  |  |  | Hearing Loss |  |  |  |
| Tennis Elbow R/L |  |  |  |  | Poor Eyesight |  |  |  |
| Back/Neck Problems |  |  |  |  | Fainting |  |  |  |
| Limited Limb Movement |  |  |  |  | Polio |  |  |  |
|  |  |  |  |  | Other: |  |  |  |
| **LUNGS** |  | **YES** | **NO** |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |
| 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? | | | | | | | | | |  |  |  | |