PERSONAL AND CONTACT INFORMATION

NAME (LAST, FIRST, MIDDLE)		NICKNAME	DOB	AGE	☐MALE ☐FEMALE
STREET ADDRESS		CITY	STATE	ZIP CODE	
PRIMARY PHONE	SECONDARY PHONE	EMAIL			
PREFERRED METHOD OF CONTACT ☐CALL ☐TEXT ☐EMAIL ☐OTHER:		EMERGENCY CONTACT (NAME AND PHONE)			
OCCUPATION (CURRENT OR FORMER IF RETIRED OR DISABLED)		CURRENTLY EMPLOYED? ☐YES ☐NO ☐RETIRED ☐DISABLED			

CONDITION / SYMPTOMS

DESCRIPTION AND DURATION OF CONDITION / SYMPTOMS
LIMITATIONS OR ALTERATIONS IN FUNCTION OR LIFESTYLE **DUE TO THIS CONDITION**
CURRENT OR PREVIOUS TREATMENT FOR THIS CONDITION AND EFFECTS / OUTCOMES

MEDICAL HISTORY

PLEASE CHECK ANY CONDITIONS FOR WHICH YOU **HAVE EVER** BEEN DIAGNOSED AND PLEASE PROVIDE ANY RELEVANT DETAILS (USE ADDITIONAL SPACE BELOW IF NEEDED)	
☐ HEART CONDITIONS	☐ TIA
☐ HIGH BLOOD PRESSURE	☐ BRAIN OR SPINAL CORD SURGERY
☐ LOW BLOOD PRESSURE	☐ SEIZURES
☐ ANEURYSMS	☐ PARKINSON'S
☐ TYPE 1 DIABETES	☐ OSTEOPOROSIS
☐ TYPE 2 DIABETES	☐ BULGING OR HERNIATED DISCS
☐ CANCER	☐ JOINT REPLACEMENT
☐ STROKE	☐ METAL HARDWARE
☐ OTHER (OR ADDITIONAL SPACE)	