Known medical conditions:

Cancer		Muscle/Joint disorders		Diabetes		Pregnancy/Nursing	
Heart Problems		Carpel Tunnel		Hernia		Epilepsy/Seizures	
Lung Problems		Multiple Sclerosis		Stroke		Contagious Disease	
Thyroids Problems		Rheumatoid Arthritis		Depression		Bruise easily	
Head or neck injury		Osteoarthritis		Anemia		TB	
Osteoporosis		Kidney Problems		Back Pain		AIDS	
Dizziness		High Blood Pressure		Headaches		Fungal Infections	

Other medical conditions not listed: _____

Do you have any vision or hearing impairments?_____

Are you pregnant? ____ Do you have a pacemaker?____ Do you have a Porta-catheter? _____
Any known allergies? _____to what?_____

Please list any medications you are taking.	**Dose**	**Frequency**

Habits	**Heavy**	**Moderate**	**Light**	**None**	**Comments**
Alcohol	☐	☐	☐	☐	
Coffee/Tea	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	
Weekly Sugar	☐	☐	☐	☐	

Do you actively participate in: _____Yoga ____Meditation ____Stretching ____Other Exercise
_____*Sitting* for long periods _____*Standing* for long periods _____Repetitive motions

_____ _____
Signature Date