MEDICAL SCREENING QUESTIONNAIRE

Name: ______________________ Date of Birth: ______________________

1. **Do you presently or have you ever suffered from any of the following?** *(Check all that apply)*

- ☐ Heart problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Lung problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Broken bones / fractures
- ☐ Allergies:______________________________
- ☐ Arthritis (eg. rheumatoid)
- ☐ HIV / AIDS
- ☐ Kidney problems
- ☐ Repeated infections
- ☐ Thyroid problems
- ☐ Skin disease or sensitivity
- ☐ Depression
- ☐ Asthma
- ☐ Epilepsy / Seizures
- ☐ Hepatitis

2. Have you had any surgeries or major dental work? *(Please list)*

______________________ ______________________

______________________ ______________________

3. Please provide a list of your current medications:

______________ ______________ ______________

______________ ______________ ______________

4. Do you smoke? ☐ Yes ☐ No are you interested in quitting? ☐ Yes ☐ No
5. Do you have a pacemaker? ☐ Yes ☐ No
6. Do you suffer from insomnia (disturbed sleep)? ☐ Yes ☐ No
7. Do you feel that you currently have significant stress in your life? ☐ Yes ☐ No
8. FOR WOMEN: Are you currently pregnant or think you may be pregnant? ☐ Yes ☐ No
9. I am **optimistic** that my present problem will improve. (Please circle one)

1	2	3	4	5
Strongly disagree	Disagree	No opinion	Agree	Strongly Agree

Signature: ______________________ Date: ______________