

Patient Name: _____ Patient ID _____

17. Other health problems may affect your treatment. Please check (✓) any of the following that apply to you:

- Arthritis (rheumatoid / osteoarthritis)
- Osteoporosis
- Asthma
- Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema
- Angina
- Congestive heart failure (or heart disease)
- Heart attack (Myocardial infarction)
- High blood pressure
- Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- Stroke or TIA
- Peripheral Vascular Disease
- Headaches
- Diabetes Types I and II
- Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- Visual impairment (such as cataracts, glaucoma, macular degeneration)
- Hearing impairment (very hard of hearing, even with hearing aids)
- Back pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- Kidney, bladder, prostate, or urination problems
- Previous accidents
- Allergies
- Incontinence
- Anxiety or Panic Disorders
- Depression
- Other disorders
- Hepatitis / AIDS
- Prior surgery
- Prosthesis / Implants
- Sleep dysfunction
- Cancer

18. Height: _____ ft. _____ in. Weight: _____ lbs.

19. This is a statement other patients have made.

"I should not do physical activities which (might) make my pain worse."

Please rate your level of agreement with this statement.

- Completely Disagree
- Somewhat Disagree
- Unsure
- Somewhat Agree
- Completely Agree