General and Medical History

Name: _____ **Date:** _____

Occupational

What is your current occupation?

_____

Does your occupation require extended periods of sitting? Yes No
Does your occupation require repetitive movements? (If YES, please explain.)

_____

Does your occupation require you to wear shoes with a heel (e.g., dress shoes)? Yes No
Does your occupation cause you mental stress? Yes No

Recreational

Do you partake in any recreational physical activities (golf, skiing, etc.)? (If YES, please explain.)

_____

Do you have any additional hobbies (reading, video games, etc.)? (If YES, please explain.)

_____

Medical

Have you ever had any injuries or chronic pain? (If YES, please explain.)

_____

Have you ever had any surgeries? (If YES, please explain.)

_____

Has a medical doctor ever diagnosed you with a chronic disease, such as heart disease, hypertension, high cholesterol, or diabetes? (If YES, please explain.)

_____

Are you currently taking any medication? (If YES, please explain.)

_____
_____
_____

Please list GOALS and ANY Additional Information You Would Like To Share:

_____
_____
_____
_____
_____
_____
_____