Name:

DOB:

Date:

Please indicate the condition(s) you you have been or are currently receiving treatment for:

- Acquired Respiratory Distress Syndrome
- Allergies
- Angina
- Anxiety or Panic Disorders
- Arthritis
- Asthma
- Back Injury
- Bleeding Disorders
- Bowel / Bladder Abnormalities
- Cancer
- COPD (Chronic Obstructive Pulmonary Disease)
- Congestive Heart Failure
- Defibrillator
- Degenerative Disc Disease
- Depression
- Diabetes
- Dizzy or Fainting Spells
- Emphysema
- Epilepsy or Seizure Disorder
- Fracture
- Headaches
- Hearing Impairment
- Heart Attack
- Hepatitis A, B, C
- Hernia
- High Blood Pressure
- HIV / AIDS
- Hypoglycemia
- Immunosuppressant Condition or Medication
- Kidney Problems
- Liver / Gallbladder Problems
- Metal or Surgical Implants
- Multiple Sclerosis
- Nausea / Vomiting
- Osteoporosis
- Pacemaker
- Parkinson's Disease
- Peripheral Vascular Disease
- Pregnancy
- Ringing in Your Ears
- Sexual Disfunction
- Skin Abnormalities
- Smoking
- Special Diet Guidelines
- Stroke or TIA
- Tuberculosis
- Upper Gastrointestinal Disease
- Visual Impairment
- OTHER: ____

Are you taking medications? If yes, please list or provide an updated list for us to copy:

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