PARTICIPANT INFORMATION

Participant's Full Name:_____ Today's Date:_____

Street::_____ Apt No.:_____

City:_____ State:_____ ZIP:_____

Birth date:_____/_____/_____ Age:_____ Sex: Male Female

Social Security#: _____

Marital Status: Single Married Widowed Separated Divorced

Home Phone:_____ Work Phone:_____

Cell Phone:_____ E Mail:_____

Occupation:_____ Employer:_____

Employer Address:_____ Phone:_____

In Case Of Emergency, Contact:_____

Relationship:_____ Home Phone:_____ Cell or Work Phone:_____

PAYMENT INFORMATION

Who is responsible for this account?_____ Relationship to patient? _____

PARTICIPANT HISTORY

Have you been diagnosed with any **medical conditions** in the past?: ___No ___Yes; If yes, please describe: _____
_____
_____

Please describe any history of **falls and/or head injuries**: _____
Please describe any history of **broken bones and/or dislocations**: _____
Please describe any history of **surgeries**: _____

Current **Exercise** Level: ___None ___Moderate ___Daily ___Heavy; Current **Work** Activity: ___Sitting ___Standing ___Light ___Heavy
Current **Habits**: ___Smoking (___Packs/Day); ___Alcohol (___Drinks/Week); ___Coffee (___Cups/Day); ___Stress Level (___0-10, 10 Highest)

Please list any **medications** you are presently taking: _____
Please list any **allergies** that you currently have: _____
Please list any **vitamins/herbs/minerals** you currently take: _____

Participant Name: _____ Date: _____

Participant Signature: _____