



**Pre-Qualifying Intake**  
*Please complete all questions*

FIRST NAME	LAST NAME	DATE OF BIRTH	AGE

ADDRESS	PHONE#

HEIGHT	WEIGHT

LIST OF MEDICATIONS

	YES	NO
<b>Any hospitalizations 2 or more times overnight</b>		
<b>Heart</b>		
<b>Lung</b>		
<b>Circulatory</b>		
<b>Stroke</b>		
<b>Kidney</b>		
<b>Liver</b>		
<b>Cancer</b>		