**Circle any activities which are affected by your pain or symptoms:**

Bending
Getting in and out of car
Climbing stairs
Sitting
Dressing
Standing
Walking
Exercising
Hoursework
Lifting
Lying in bed/sleeping
Changing positions
Turning or bending neck
Driving a vehicle
Taking a deep breath
Dressing
Other _____

**Circle any conditions you currenly have, or have had in the past:**

Headaches
Migraines
Numbness or tingling into arms/hands
Numbness or tingling into legs/feet
Numbness or tingling into face
Neck pain
Back pain
Ankle pain
Stroke
Digestive issues
Blood clotting disorder
High blood pressure
Low blood pressure
Knee pain
Shoulder pain
Hip pain
Chest pain
Shortness of breath
Diabetes
Bowel or bladder incontinence
Heart attack
Seasonal allergies
Skin rash
Osteopenia/osteporosis
Dizziness or vertigo
Cancer
Other _____

**What are your goals for treatment? Circle all that apply**

Wellness/preventative care
Decrease pain
Increase range of motion
Stress management
Return to normal activities
Recover more quickly from training
Other _____