

## Date: Major activities of daily living Using the scale below please number the following activities. 8 9 7 Unable to perform Able to perform Walking Sitting Sleeping Standing Activities with Children Work Relaxing Gardening Driving Heavy Chores Bending/Lifting Stretching Going out with friends irritability Dressing/Bathing Reading Concentration Memory problems Erectile Dysfunction Please answer the following questions carefully and answer each one honestly: Check YES or NO 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes () No () 2.Do you feel pain in your chest when you are not doing physical activity? Yes \( \) No \( \) 3.In the past month, have you had chest pain when you were not doing physical activity? Yes ( ) No ( ) 4.Do you lose your balance because of dizziness or do you ever lose consciousness? Yes \( \) No \( \) 5.Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? Yes \( \) No \( \) 6.Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? Yes ( ) No ( )

7.Do you know of any other reason why you should not do physical activity? Yes () No ()

## HEALTH HISTORY

What treatment ha	ave you alr	ready red	ceived for your condit	tion? 🗌 M	ledication	s Surgery 1	Physical	herapy			
	Chiroprac	tic Servic	ces	☐ Other							4
Name and address	s of other	doctor(s	) who have treated ye			on					
						32.			od Test		147
Date of Last: Physical Exam  Spinal Exam  Dental X-Ray											
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	1-000	12-12-170	cate if you have had					e anno 1866 de alegan			3744
AIDS/HIV	☐ Yes		Diabetes		□ No	Liver Disease	Yes	The street of th	Rheumatic Fever	Yes	
Alloren Chata	Yes		Emphysema		□No	Measles	Yes		Scarlet Fever	☐ Yes	∐ No
Allergy Shots Anemia	☐ Yes		Epilepsy			Migraine Headaches			Sexually Transmitted		
Anorexia	☐ Yes	□ No	Fractures	Yes		Miscarriage	Yes		Disease	☐ Yes	☐ No
Appendicitis	☐ Yes	□ No	Glaucoma Goiter	☐ Yes		Mononucleosis	☐ Yes		Stroke	☐ Yes	☐ No
Arthritis	☐ Yes	□ No	Gonorrhea		□No	Multiple Sclerosis Mumps	☐ Yes		Suicide Attempt	☐ Yes	☐ No
Asthma	Yes	□ No	Gout	☐ Yes		Osteoporosis	☐ Yes		Thyroid Problems	☐ Yes	☐ No
Bleeding Disorders	<del></del>	□ No	Heart Disease	☐ Yes		Pacemaker	☐ Yes	-	Tonsillitis	Yes	□ No
Breast Lump	☐ Yes	□ No	Hepatitis	☐ Yes	CONTRACTOR OF THE PARTY OF THE	Parkinson's Disease			Tuberculosis	Yes	□ No
Bronchitis	☐ Yes	□ No	Hernia		□ No	Pinched Nerve	Yes		Tumors, Growths	☐ Yes	☐ No
Bulimia		□ No	Herniated Disk	☐ Yes	1-1-0011	Pneumonia	Yes	□ No	Typhoid Fever	Yes	☐ No
Cancer	☐ Yes	□ No	Herpes		□ No	Polio	☐ Yes		Ulcers		☐ No
Cataracts	☐ Yes	□ No	High Blood	1C3		Prostate Problem	Yes	□ No	Vaginal Infections	☐ Yes	☐ No
Chemical	□ .00		Pressure	☐ Yes	□No	Prosthesis	Yes	□ No	Whooping Cough	Yes	☐ No
Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	□No		☐ Yes		Other		
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheumatoid Arthritis					
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