Patient Name_____ SS#_____

Cell Phone_____ Email_____

Marital Status:
❑Married ❑Single ❑Widowed ❑Divorce

What are your typical work activities?
❑Sitting ❑Standing ❑Light Labor ❑Heavy Labor

What activities is your current condition preventing you from doing?

_____
_____
_____

Do you normally exercise? ❑Yes ❑No

If yes, what activities?_____

How often?_____

Do you smoke? ❑Yes ❑No

If yes, how many cigarettes per day?_____

Do you drink alcohol? ❑Yes ❑No

If yes, approximately how many drinks per week?_____

Do you commonly feel the following (check all that apply)?
❑Stress ❑Depression ❑Fatigue ❑Anxiety

On a scale of 0 to 10 (0=none, 10=unbearable) please rate your level of stress, depression, fatigue, and/or anxiety.

_____
0 1 2 3 4 5 6 7 8 9 10

How would you rate your nutrition and eating habits (0=very poor, 10=excellent)

_____
0 1 2 3 4 5 6 7 8 9 10

EMERGENCY CONTACT:
Name_____Relationship_____

Home Phone_____ Work Phone_____