Sample Questionnaire:

First Name: ____________________ Middle Initial: __ Last Name: ______________________

Address: ____
Street City State Zip

Phone# ____
Home Cell Work

In case of emergency contact: ____
Name Phone Relationship

Drivers license: ___________________________ E-mail: ___________________________

If I am taking any medications (e.g., "blood thinners"), I agree to disclose them below.

Please circle the appropriate answer to each of the following question if you answer "YES" to any of the questions please explain as clearly as possible.

Do you suffer from stress frequently?	Yes	No______________________
Do you experience frequent headaches?	Yes	No______________________
Are you pregnant?	Yes	No______________________
Are you wearing contact lenses?	Yes	No______________________
Are you wearing dentures?	Yes	No______________________
Have you had a car accident or other injuries?	Yes	No______________________
Are you sensitive to touch or pressure?	Yes	No______________________
Do you bruise easily?	Yes	No______________________
Have you had any surgeries?	Yes	No______________________

Do you currently have any of the following conditions:

Diabetes	Yes	No______________________
Arthritis	Yes	No______________________
Spinal diseases	Yes	No______________________
High blood pressure	Yes	No______________________
Low blood pressure	Yes	No______________________
Upper back and/or neck pain	Yes	No______________________
Anxieties and/or clinical depression	Yes	No______________________
Osteoporosis	Yes	No______________________
Psychiatric disorders	Yes	No______________________
Lower back and or lower extremities pains	Yes	No______________________
Contagious/communicable diseases	Yes	No______________________

Other conditions____
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How often do you work out?	Never	Rare	1per week	2 per week	3 per week	5 per week	Daily
What is average duration of each workout?	10min	15min	30min	45min	1hour	2hrs	>2 hrs

Do you experience difficulties during work out?	Yes	No______________________
Did you ever receive any rehabilitative treatment to eliminate exercise stress side effects?	Yes	No______________________

If yes, please describe what type of rehabilitative treatment, how many times and how often.

Please list all medications (prescription and over-the-counter), dietary supplements, and herbs that you are currently taking: