

Your Name: Date Of Birth:		
Male 🗆 Female 🗆	Smoker 🗆 Non-smoker 🗅	
Heightftin	Weight ibs	
Do you currently engage in regular exercise or any sports? Y Do you require assistance with any activities of daily living?		YES / NO YES / NO YES / NO YES / NO
ALS (Amyotrophic la Parkinsons Alzhelmers Memory or cognitive Disorder of the lungs High blood pressure High cholesterol Heart attack Coronary artery dise Circulatory or blood History of stroke or 1	impairment / Dementia s or respiratory system(emphysema/ COPD) ase vessel disorder TA (mini stroke) he neck, abdomen or legs	YES / NO
Cancer: Type Stage Date of Diagnosis Date of Diagnosis Type Stage Date of Diagnosis Please list all current medications: Please list any surgeries you have undergone: Please provide additional health impairments not listed above:		
Your Signature: Date:		