



PRE-ASSESSMENT QUESTIONNAIRE

1. Do you *or have you had* any of the following problems?

- | | |
|----------------------|----------------------------|
| A) Heart Disease | B) High/Low blood Pressure |
| C) Lung Disease | D) Diabetes |
| E) Epilepsy | F) Arthritis |
| G) Tumor/cancer | H) HIV/AIDS |
| I) Hepatitis A, B, C | J) Osteoporosis/Osteopenia |

2. Do you smoke? Y N If yes, how many packs/day _____

3. Do you have vision or hearing impairments? _____

4. Do you have a pacemaker or metal implant? _____

5. Are you or do you suspect you are pregnant? _____

6. Have you had any surgery in the past? Please list: _____

7. Do you have any allergies? Are you allergic to latex? _____

8. Do you take any medications? _____

Date: _____

Signature of Client: _____