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 (please list. If you are taking a large list of medications, you can provide a copy of the list from your pharmacy)? _____

_____

Date: _____ Signature of Client: _____