Patient Information Worksheet – Please complete and return at end of class

Name: _____Age:_____Email:_____

- Please check the boxes that apply to you

Quick Health History	Medication treatments for:	Miscellaneous
Coronary Artery Disease ☐ Surgery year / Bypass / Stent Congestive Heart Failure ☐ High Blood Pressure ☐ Blood Clots (DVT) ☐ Kidney Disease ☐ Sleep Apnea ☐ Use CPAP ☐ **Please feel free to elaborate on other side	Depression ☐ Anxiety ☐ Panic attack ☐ Pain: are you on any of the following? ☐ anti-inflammatory meds ☐ narcotic meds ☐ under care of pain doctor How long on meds?_____ Blood thinners Coumadin ☐ Plavix ☐ Aspirin ☐ Other ☐ _____ Reason_____	Confusion Daytime ☐ Nighttime ☐ With pain medication ☐ Smoke ☐ ___cigarettes/day Drink ☐ ___/week Is there anything else you would like me to know?
Allergies Latex ☐ Medications_____ _____ Food_____ _____	**PAIN GOAL** **(please leave blank until class)** On a scale of 1-10 as explained, what is *your* pain goal? _____	**Special Diet considerations:**