Personal History: Please check "yes" if it applies.

Condition	Do you have this problem now? Yes	Did you have this problem in the past? Yes	Are you currently being treated for this? Yes
A physical disability	☐	☐	☐
Alcoholism/Addiction	☐	☐	☐
Any suicidal thoughts	☐	☐	☐
Appetite problems	☐	☐	☐
Cancer/Tumor	☐	☐	☐
Chest pain or pressure	☐	☐	☐
Chronic pain	☐	☐	☐
Death of a family member this year	☐	☐	☐
Diabetes	☐	☐	☐
Epilepsy	☐	☐	☐
Eye problems, blurred or worsening vision	☐	☐	☐
Fainting, dizziness, or light-headed feelings	☐	☐	☐
Feelings of loneliness or depression	☐	☐	☐
Gained or lost over 10 lbs. recently	☐	☐	☐
Hearing problems	☐	☐	☐
Heart palpitations, irregular or racing heartbeat	☐	☐	☐
High blood pressure	☐	☐	☐
Kidney Problems	☐	☐	☐
Liver Problems	☐	☐	☐
Lung Problems	☐	☐	☐
Mental Illness	☐	☐	☐
MRSA	☐	☐	☐
Nervousness, anxiety, irritability or anger	☐	☐	☐
Other contagious health condition (e.g. lice, scabies)	☐	☐	☐
Problems with memory or concentration	☐	☐	☐
Rheumatism/Arthritis	☐	☐	☐
Seizures or convulsions	☐	☐	☐
Sexual problems	☐	☐	☐
Shakiness or trembling	☐	☐	☐
Significant headaches	☐	☐	☐
Sleep problems or insomnia	☐	☐	☐
Stroke	☐	☐	☐
Thyroid Problems	☐	☐	☐
Traumatic brain injury (e.g. concussion, hit in head)	☐	☐	☐
Unexplained bruises or sores that don't heal	☐	☐	☐
Other	☐	☐	☐