Evaluation Data	DOB	
Evaluation Date	Doctor	

Name	
DOB	
Doctor	
Medical Record #	

When did you	r current condition begin	?			
What original	y caused your current sy				
	Not sure how it s		Fall/Slip		Yard work
	Motor vehicle ac	cident	Bend/twist		Sports activi
	Cough/sneeze Other:		Lifting		Shoveling
	Otner.				
	ER been diagnosed as h				
	Heart problems		Rheumatoid		
	High blood press Circulation proble		Other arthritic	ic conditions	
	Circulation proble		Depression Hepatitis		For Women:
	C	nchitis	Hepatitis Tuberculosis	3	Are you or could
	Empnysema/bro Chemical depen	alaca acci	Stroke	•	you be pregnant?
	Thyroid problems		Kidney probl	lems	Yes No
	Diabetes		Anemia	.011.0	(Circle One)
	Multiple sclerosis		Epilepsy/seiz	zures	(55.5 55)
	Cancer If Yes,				
	Cancer II 163,	wiiat kiiiu.			
Please list an reason for the Dat	y surgeries or other co e surgery or hospitalization e Reason	nditions for which you on.	have been hospitalize	ed, including appro	
Please list an eason for the Dat 1	y surgeries or other co e surgery or hospitalization e Reason	nditions for which you on.	have been hospitalize Date 4 5	ed, including appro	
Please list an eason for the Dat 1 2 3	y surgeries or other co e surgery or hospitalization e Reason	nditions for which you on.	have been hospitalize Date 4 5	ed, including appro	
Please list an reason for the Date 23	y surgeries or other coes surgery or hospitalization Reason	nditions for which you on.	have been hospitalize Date 4 5 6	ed, including appro	
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