



## Client Information

Client Name: \_\_\_\_\_

## Questions That May Result in a Decline

Are you pending surgery? _____	Yes	No
Are you in the military with active deployment papers? _____	Yes	No
Have you filed bankruptcy or had a bankruptcy discharged in the last 2 years? _____	Yes	No

## Potential Exclusions or Impaired Risks

### Tobacco, Nicotine, Marijuana Usage

Do you smoke cigarettes or use either nicotine and/or marijuana products? _____	Yes	No
If yes, which products do you use?      Cigarettes      Tobacco/Nicotine Products      Marijuana/CBD		
If you use Marijuana/CBD products, are they prescribed? _____	Yes	No
If you use Marijuana/CBD products, please detail how often you use them and what products you use: _____		

## Height, Weight, & Build-Related Concerns

What is your current height? \_\_\_\_\_

What is your current weight? \_\_\_\_\_

Have you undergone a gastric bypass procedure in the last 5 years? _____	Yes	No
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## Medical Procedures & Surgeries

Does your client have any planned or pending tests that need to be completed by a physician? _____	Yes	No
Do you regularly see a chiropractor or have you been seen by one in the last 2–3 years? _____	Yes	No
If yes, please detail how often you see a chiropractor: _____		
Have you ever had a joint replacement? _____	Yes	No
Have you had a fracture repair using metal plates, pins, or other hardware? _____	Yes	No

## Medical Diagnosis

Have you been diagnosed with any of the following? (Check all that apply.)

Arthritis	Crohn's Disease or Colitis	Cancer (last 10 years)	Diverticulitis	Fibromyalgia
Heart Attack or Stroke (last 10 years)	HIV	Irritable Bowel Syndrome (IBS)	Lupus	Multiple Sclerosis (MS)
Pregnancy Complications (under age 50)	Sleep Apnea	Type 1 Diabetes	Type 2 Diabetes	
	If yes, CPAP used?	If Type 2, last A1C reading:		
	Yes No			

If you have been diagnosed with any of the conditions above, please provide the following information:

- Date of diagnosis
- Name of medication
- Dosage of medication
- Treatment plan (including medication and non-medication such as injections, physical therapy, etc.)
- Prescription or over the counter
- Dates medication was or is being taken

## Mental & Psychological

- Are you currently taking more than one medication for a mental or psychological condition? \_\_\_\_\_ Yes No
- Are you currently taking any anxiety medication(s) prescribed due to work-related stress? \_\_\_\_\_ Yes No
- Are you currently taking medication prescribed for ADHD? \_\_\_\_\_ Yes No

If you answered yes to any of the questions above, please provide the following information:

- Date of Diagnosis
- Prescription or over the counter
- Dates medication was or is being taken
- Name of medication
- Dosage of medication