Have you ever been diagnosed with any of the following conditions (check all that apply)?

- cancer (type)
- heart disease
- high blood pressure
- asthma
- osteoporosis
- rheumatoid arthritis
- anxiety/depression
- lung problems
- anemia
- thyroid problems
- diabetes
- disordered eating
- headaches/migraines
- stroke
- back/neck problems
- kidney/liver problems
- high cholesterol
- other

FOR Women: Are you currently pregnant or think you might be pregnant? YES  NO

Do you have allergies to oils, nuts or scents? YES  NO
If yes, please explain ____________________________________________________________

<table>
<thead>
<tr>
<th>Over the past 2 weeks, how often have you been bothered by any of the following problems?</th>
<th>Not At All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

List your symptoms (injuries/joint disorders/heath concerns, etc.) in order or importance. Please mark the location of the symptoms listed on the body chart.

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________
4. __________________________________________________________________________
5. __________________________________________________________________________

Do you have any activities or positions that aggravate your condition(s):
________________________________________________________________________________
________________________________________________________________________________

Please list any current physical limitations related to your injuries: ________________________________
________________________________________________________________________________
________________________________________________________________________________

Do you have a regular exercise program/routine? Yes  No  If yes, please describe____________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
Indicate how you are dealing with daily stress: not well 1 2 3 4 5 6 7 8 9 10 well
Indicate your energy level: very low 1 2 3 4 5 6 7 8 9 10 very high
Please describe your health and wellness goals:
______________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________

Education interests:
☐ stress reduction techniques ☐ self myofascial release ☐ meal planning
☐ ergonomics ☐ posture ☐ women’s health
☐ exercise program ☐ healthy food preparation ☐ healthy aging
☐ weight management ☐ proper exercise technique ☐ other ________________

Thank you for your willingness to share this information and to take part in the WorkStrong Program. We look forward to working with you to make lifestyle changes to meet your health and wellness goals.