Name:_____
Address:_____
City/State:_____
Telephone Number:_____
Cell Phone Number:_____
E-mail address:_____
Date of birth:_____

Marital status: ( ) single ( ) Married ( ) Divorced ( ) Widowed
If Married, Spouse's name: _____
Who should we contact in case of an emergency: _____
Phone Number: _____

Are you suffering from the following:	Y	N
a. Disorder of eyes (including double vision), ears, nose, mouth, throat or speech	()	()
b. Dizziness, loss of balance, headaches, seizures or convulsions, muscle Weakness, tremor, paralysis, stroke, memory loss, or any disease of the Brain or nervous system	()	()
c. Anxiety, depression, stress, or any psychological or emotional condition Or disorder	()	()
d. Persistent shortness of breath, hoarseness, coughs, coughing up blood, asthma Emphysema, tuberculosis, or any lung or respiratory disorder	()	()
e. Jaundice, hepatitis, intestinal bleeding, ulcer, hernia, colitis, diverticulitis, recurrent indigestion, or any disorder of the stomach, intestines, liver, Gall bladder or pancreas	()	()
f. High Blood Pressure, chest pain, chest discomfort, chest tightness, Irregular heart beat, heart murmur, heart attack or any disorder on the heart Or blood vessels	()	()
g. Sugar, albumin, blood or pus in urine, sexually transmitted or venereal disease, or any disorder or the kidney, bladder, prostate or reproductive Organs	()	()
h. Diabetes, thyroid, or any glandular (endocrine) disorder	()	()
i. Cancer, tumor, polyp, or disorder of the lymph gland(s) or breast(s)	()	()
J. Anemia, bleeding tendency, or any disorder of the muscles, bones, joints,		

Spine, back or neck	()	()
k. Arthritis, sciatica, gout or any disorder of the muscles, bones, joints, Spine, back or neck	()	()
L. Chronic or unexplained fatigue, fever or illness	()	()
m. Any allergies	()	()
n. Any disorders of the skin	()	()
o. Deformity, lameness or amputation	()	()

a. Have you sought or received counseling or treatment for the use of Alcohol or drugs or been absent from work because of alcohol abuse Or drug abuse	()	()
b. In the last 10 years, have you used marijuana, cocaine, heroin, Amphetamines or hallucinogens	()	()
c. In the last 10 years, have you used any tranquilizers, sedatives or Narcotic drugs	()	()
d. In the last 10 years, have you used legally prescribed drugs in Excess or dosages prescribed by a physician or medical practitioner	()	()

a. Are you pregnant? If yes, due date_____

Other than previously stated on the application, in the last five years have you:

a. Consulted any other health care providers (medical doctor, psychiatrist, psychologist, chiropractor, counselor, therapist or other)	()	()
b. Been a patient in a hospital, clinic or medical facility	()	()
c. Had any diagnostic studies (EKG, x-ray, blood tests or any other)	()	()
d. Had surgery	()	()
e. Been advised to have any test, consultation, hospitalization, or surgery that was not complete	()	()

a. During the last 6 months have you worked your regular occupation less than your usual number of hours per week because of any sickness or injury	()	()
b. Have you ever requested or received payment, benefits, or a pension because of any injury, accident, sickness or disability	()	()

To the best of my knowledge all the above is true:

_____

Parkers Place
N48 W36105 E Wisconsin Ave
Oconomowoc WI 53066