STAYING FIT WHILE YOU SIT

Evaluation

Name _____ Age _____

Phone: Home _____ Work _____ Cell _____

Hours/Week Sitting on the Job _____

Computer Work: Yes / No Typing: Yes / No Telephone Work: Yes / No Other _____

✔ **Check off any of the following symptoms you have experienced in the past month:**

- ☐ Headaches
- ☐ Fatigue
- ☐ Digestive Disturbance
- ☐ Irritability
- ☐ Interruption in Sleep Pattern
- ☐ Low Back Pain
- ☐ Pain Between Shoulder Blades
- ☐ Neck Pain
- ☐ Tension/Headaches
- ☐ Other _____
- ☐ Tension Across Top of Shoulders
- ☐ Numbness/Tingling in Arms of Hands
- ☐ Numbness/Tingling in Legs of Feet
- ☐ Eye Strain

Which of the above bothers you the most? _____

How long have you had it? _____

When it is at the worst how does it feel? _____

Does this cause you to be:

- ☐ Moody
- ☐ Restricted on daily activities

Does this affect your work:

- ☐ Decision Making
- ☐ Poor Attitude
- ☐ Decreased Productivity
- ☐ Exhausted at End of Day
- ☐ Unable to Work Long Hours

Would You Like To Get Rid of the Problem? ☐ Yes ☐ No

If your answer is Yes, there are several alternatives available to you.

Please check the item most appropriate for you.

- ☐ I would like to come to the Acupuncturists office for a consultation. This will allow me to find out if I can be helped by Acupuncture without any financial barriers.
- ☐ I would like the Acupuncturist to call me to discuss my health problems before making an appointment.