PATIENT PROFILE

Please provide us with the following information about yourself:

1. What is your age at this time?

2. What is your sex (male or female)?

3. What is your racial background? (check one)
   - White
   - Black
   - Hispanic
   - Asian or Pacific Islander
   - American Indian or Alaskan Native
   - Other (specify):

4. What is your current marital status? (check one)
   - Married
   - Separated
   - Divorced
   - Widowed
   - Never married

5. What is the highest level of education you have received? (check one)
   - Less than high school diploma
   - High school diploma or GED
   - One to four years of college
   - College graduate
   - Professional or graduate school

6. How long have you had fibromyalgia (months, years)?

7. Have you had sleep problems?
   - Yes
   - No

7a. If yes, did they predare your fibromyalgia pain?
   - Yes
   - No

8. Have you had problems with fatigue?
   - Yes
   - No

8a. If yes, did they predate your fibromyalgia pain?
   - Yes
   - No
9. Who diagnosed your fibromyalgia? (Check all that apply) Specify date of diagnosis (month & year)

- Rheumatologist
- Internist
- General practitioner/family doctor
- Psychiatrist
- Orthopedist
- Other (please specify):

10. Who follows your fibromyalgia? (Check all that apply)

- Rheumatologist
- Internist
- General practitioner/family doctor
- Psychiatrist
- Orthopedist
- Other (please specify):

11. Are you currently seeing a psychiatrist, psychologist or counselor for any related problems?

  Yes
  No

11a. If you answered yes to the above question, how often do you see this professional?

12. Please list your current medications.

<table>
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<tr>
<th>Name of medication</th>
<th>Dose (5 mg, 10 mg, etc)</th>
<th>Frequency (1x/day, 2x/day, etc)</th>
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13. Please list any treatment or therapy (including any prior Feldenkrais experience) you have received, other than medications, for your fibromyalgia. Please include dates.
14. Check any other types of arthritis that you have. (Check all that apply)

- Rheumatoid arthritis
- Systemic lupus erythematosus
- Scleroderma
  - Psoriatic Arthritis
  - Reiter's syndrome
  - Gout
- Low back pain
- Tendonitis/Bursitis
- Osteoporosis

Other (please specify):

15. Is your health currently affected by any of the following medical problems?  

YES   NO

- High blood pressure
- Heart disease
- Mental illness
- Diabetes
- Cancer
- Alcohol or drug abuse
- Lung disease
- Kidney disease
- Liver disease
- Ulcer or other stomach disease
- Anemia or other blood disease
- Depression
- Anxiety

Other (please list):  

__________________________