(Client's Name) : _____ (Date of birth) _____

Medical condition (please add all other conditions not mentioned)	**Is this condition considered as being : severe, moderate or light?**	**Condition existed as of (date)?**	**Condition expected to last one year or more?**	**Are there restrictions to the daily activities resulting from this condition? (enumerate and explain briefly)**
		Yes / No	Yes / No	
		Yes / No	Yes / No	
		Yes / No	Yes / No	
		Yes / No	Yes / No	
		Yes / No	Yes / No	
		Yes / No	Yes / No	

Completed by Dr._____ on _____ _____

Doctor's signature