

► Health History Questionnaire

ANSWER EACH QUESTION BY PRINTING THE NECESSARY INFORMATION. YOUR ANSWERS ARE CONFIDENTIAL.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip		
Home Phone:	Work Phone:	

MEDICAL INFORMATION

Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list reason:		
Are you taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>(If yes, complete the following)</i>		
Type:	Dosage/Frequency:	Reason for Taking:
<hr/>		
<hr/>		
<hr/>		
Please list any allergies:		
<hr/>		
Has your doctor ever said your blood pressure was too high?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you over the age of 65?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you unaccustomed to vigorous exercise?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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MEDICAL INFORMATION, CONTINUED

Is there any reason not mentioned why you should not follow a regular exercise program? Yes No
If yes, please explain:

Have you recently experienced any chest pain associated with either exercise or stress? Yes No
If yes, please explain:

SMOKING

Please check the box that describes your current habits:

- Non-user of former user; Date quit: _____
- Cigar and/or pipe
- 15 or less cigarettes per day
- 16 to 25 cigarettes per day
- 26 to 35 cigarettes per day
- More than 35 cigarettes per day

FAMILY AND PERSONAL MEDICAL HISTORY

If there is family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

- Asthma: _____
- Respiratory/Pulmonary Conditions: _____
- Diabetes: Type I: _____ Type II: _____ How Long? _____
- Epilepsy: Petite Mal: _____ Grand Mal: _____ Other: _____
- Osteoporosis: _____

LIFESTYLE AND DIETARY FACTORS

Please fill in the information below:

- Occupational Stress Level: Low / Medium / High
- Energy Level: Low / Medium / High
- Caffeine Intake/Daily: _____ Alcohol Intake/Weekly: _____
- Colds Per Year: _____ Anemia: _____
- Gastrointestinal Disorder: _____
- Hypoglycemia: _____
- Thyroid Disorder: _____
- Pre/Postnatal: _____

CARDIOVASCULAR

Please fill in the information below:

- High Blood Pressure: _____ Hypertension: _____
- High Cholesterol: _____
- Hyperlipidemia: _____
- Heart Disease: _____
- Heart Disease: _____
- Heart Attack: _____ Stroke: _____
- Angina: _____ Gout: _____

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FAMILY AND PERSONAL MEDICAL HISTORY, CONTINUED

MUSCULOSKELETAL INFORMATION

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

- Head/Neck: _____
- Upper Back: _____
- Shoulder/Clavicle: _____
- Arm/Elbow: _____
- Wrist/Hand: _____
- Lower Back: _____
- Hip/Pelvis: _____
- Thigh/Knee: _____
- Arthritis: _____
- Hernia: _____
- Surgeries: _____
- Other: _____

NUTRITIONAL INFORMATION

Are you on any specific food/diet plan at this time? Yes No
If yes, please list: _____

Do you take dietary supplements? Yes No
If yes, please list: _____

Do you experience any frequent weight fluctuations? Yes No

Have you experienced a recent weight gain or loss? Yes No
If yes, list change: _____

Over how long? _____

How many beverages do you consume per day that contain caffeine? _____

How would you describe your current nutritional habits? _____

Other food/nutritional issues you want to include (*food allergies, mealtimes, etc.*) _____

