HEALTH HISTORY QUESTIONNAIRE

Answers are confidential.

Personal Information:

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? Yes No
If yes, list reason:___________________________________
____

Are you taking any medications?
(*If yes, complete the following*)

Type	Dosage/Frequency	Reason for taking

Please list any allergies:_____________________________
____

1. Has your doctor ever said your blood pressure was too high? Yes No

2. Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise? Yes No

3. Are you over 65? Yes No

4. Are you unaccustomed to vigorous exercise? Yes No

Medical Information (CON'T):

5. Is there any reason not mentioned here why you should not follow a regular exercise program? Yes No

   If so, please explain:____

6. Have you recently experienced any chest pain associated with either exercise or stress? Yes No

   If so, please explain:____

Smoking

Please check the box that best describes your current habits:

- ☐ Non-user or 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 a 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.

- ☐ Asthma:____
- ☐ Respiratory/Pulmonary Conditions:______________________________
- ☐ Diabetes: Type 1:___________ Type 2:______ How long:_________________________
- ☐ Epilepsy: Petite Mal:_______ Grand Mal:__________ Other:______________________
- ☐ Osteoperosis:____

Lifestyle and Dietary Factors:

- ☐ Occupation 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

- ☐ High Blood Pressure:_______________ ☐ Hypertension:____________________
- ☐ High Cholesterol:____
- ☐ Hyperlipidemia:____
- ☐ Heart Disease:____
- ☐ Heart Attack:______________________ ☐ Stroke:__________________________
- ☐ Angina:___________________________ ☐ Gout:___________________________

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 specified food/nutritional plan at this time? Yes No

If yes, please list:______________________________

____

Do you take any dietary supplements? Yes No

If yes, please list:______________________________

____

Have you experienced 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/nutrition issues you want to include (*food allergies, mealtimes,etc.)?*______________

____

____

Exercise Habits:

Please check the box that best describes your work and exercise habits:

- ☐ Intense occupational and recreational exertion
- ☐ Moderate occupational and recreational exertion
- ☐ Sedentary work and intense recreational exertion
- ☐ Sedentary work and light recreational exertion
- ☐ Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Work: Minimal / Moderate / Average / Extreme

Home: Minimal / Moderate / Average / Extreme

Do you work more than 40 hours per week?____

Please make any other comments you feel are pertinent to your exercise program.

____

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____

____

____ ____________________

Signature of Client **Date**

____ ____________________

Signature of Witness **Date**