

HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your 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? <i>(if yes, complete the following)</i>	Yes	No
<u>Type</u>	<u>Dosage/Frequency</u>	<u>Reason for taking</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
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 age 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 & 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 I: _____ Type II: _____ How long? _____
- Epilepsy: Petite Mal: _____ Grand Mal _____ Other: _____
- Osteoporosis: _____

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 specific food / nutritional 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/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 moderate 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 Extremely

Home: Minimal Moderate Average Extremely

Do you work more than 40 hours a week? _____

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

Signature of Client

Date

Signature of Witness

Date