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: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____ Cell Phone: _____

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?
☐ No
☐ Yes (if yes, list reason): _____

Are you taking any medications?
☐ No
☐ Yes (if yes, complete the following)

Name/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 age 65? ☐ Yes ☐ No

4. Are you unaccustomed to vigorous exercise? ☐ Yes ☐ No

MEDICAL INFORMATION (CONT'D):

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: _____

7. Have you recently had any surgery or medical procedure?
☐ Yes ☐ No
If so, please explain: _____

Smoking: Please check the box that best describes your current habits:

☐ Non-user
☐ 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 or personal history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, add any additional information on the line provided.

Family History	**Personal History**
☐ Asthma _____	☐ Asthma: _____
☐ Respiratory/Pulmonary Conditions	☐ Respiratory/Pulmonary Conditions: _____
☐ Diabetes: Type I (How Long)_____	☐ Diabetes: Type I (How Long)_____
☐ Diabetes: Type II (How Long)_____	☐ Diabetes: Type II (How Long)_____
☐ Epilepsy: Petite Mal: _____	☐ Epilepsy: Petite Mal: _____
☐ Epilepsy: Grand Mal: _____	☐ Epilepsy: Grand Mal: _____
☐ Epilepsy: Other_____	☐ Epilepsy: Other_____
☐ Osteoperosis: _____	☐ Osteoperosis: _____
☐ High Blood Pressure:_____	☐ High Blood Pressure: _____
☐ Hypertension: _____	☐ Hypertension: _____
☐ High Cholesterol:_____	☐ High Cholesterol: _____
☐ Hyperlipidemia: _____	☐ Hyperlipidemia:_____
☐ Heart Disease: _____	☐ Heart Disease: _____
☐ Heart Attack: _____	☐ Heart Attack: _____
☐ Stroke:_____	☐ Stroke: _____
☐ Angina: _____	☐ Angina: _____
☐ Gout: _____	☐ Gout: _____
☐ Anemia: _____	☐ Anemia: _____
☐ Gastrointestinal Disorder_____	☐ Gastrointestinal Disorder: _____
☐ Hypoglycemia: _____	☐ Hypoglycemia: _____
☐ Thyroid Disorder: _____	☐ Thyroid Disorder: _____

Lifestyle and Dietary Factors (Personal Only):
Occupational Stress Level: ☐ Low ☐ Medium ☐ High
Energy Level: ☐ Low ☐ Medium ☐ High
Caffeine Intake (Daily): _____
Alcohol Intake (Weekly): _____
Number of colds per year: _____
Are you pregnant/recently pregnant: ☐ Yes ☐ No _____

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/Clavical: _____

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:

Work/Occupational:

- ☐ No work/occupational exertion
- ☐ Light work/occupational exertion
- ☐ Moderate work/occupational exertion
- ☐ Intense work/occupational exertion

Recreational/Exercise:

- ☐ No recreational/exercise exertion
- ☐ Light recreational/exercise exertion
- ☐ Moderate recreational/exercise exertion
- ☐ Intense recreational/exercise exertion

To what degree do you perceive your environment as stressful?

Work: ☐ Minimal ☐ Moderate ☐ Average ☐ Extremely

Home: ☐ Minimal ☐ Moderate ☐ Average ☐ Extremely

Other: ☐ Minimal ☐ Moderate ☐ Average ☐ Extremely

Do you work more than 40 hours a week? ☐ Yes ☐ No If yes, how many? _____

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

_____

_____

_____

_____

_____

_____ _____

Signature of Client Date

_____ _____

Signature of Witness Date