# 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? Yes No
*(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 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 boxto 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:_____
- ❑ 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 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