Health Questionnaire

Name:	**Age:**
Address:	
Address 2:	
Phone Number	
Email Address:	
Occupation:	
Emergency Contact -	Phone #

Health Questionnaire

Medical Information

Physician's Name:

Phone Number:

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: _____

_____

Health Questionnaire

Has your doctor ever said your blood pressure was too high?	☐ Yes ☐ 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?	☐ Yes ☐ No
Are you over the age of 65?	☐ Yes ☐ No
Are you unaccustomed to vigorous exercise?	☐ Yes ☐ No
Is there any reason not mentioned why you should not follow a regular exercise program? If yes, please explain:	☐ Yes ☐ No
Have you recently experienced any chest pain associated with either exercise or stress? If yes, please explain:	☐ Yes ☐ No
Do you smoke? If yes how many per day?	☐ Yes ☐No

Health Questionnaire

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

☐ Occupational Stress Level: ☐ Low / ☐ Medium / ☐ High

☐ Energy Level: ☐ Low / ☐ Medium / ☐ High

☐ Caffeine Intake/Daily:_____

☐ Alcohol Intake/Weekly:_____

Health Questionnaire

Cardiovascular

Please fill in the information below:

☐ High Blood Pressure:_____

☐ Hypertension:_____

☐High Cholesterol:_____

☐ Heart Disease:_____

☐ Heart Attack:_____

☐ Stroke:_____

☐ Angina:_____

☐ Gout:_____

MUSCULOSKELETAL INFORMATION

Please check any problems with the following:

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

Health Questionnaire

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?

Health Questionnaire

Work and Exercise Habits

My Work is ☐ Active ☐ Somewhat active ☐ Sedentary

What do you currently do for physical activity and how many times a week on average?

_____

_____

_____

Notes (Anything else you would like me to know)