

# 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. _____		
_____		
<b>Smoking</b>		
Please check the box that best describes your current habits:		
<input type="checkbox"/> Non-user or former user; Date quit: _____		
<input type="checkbox"/> Cigar and/or pipe		
<input type="checkbox"/> 15 or less cigarettes per day		
<input type="checkbox"/> 16 to 25 cigarettes per day		
<input type="checkbox"/> 26 to 35 cigarettes per day		
<input type="checkbox"/> 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.	
<input type="checkbox"/> Asthma: _____	
<input type="checkbox"/> Respiratory/Pulmonary Conditions _____	
<input type="checkbox"/> Diabetes: Type I: _____ Type II: _____ How long? _____	
<input type="checkbox"/> Epilepsy: Petite Mal: _____ Grand Mal _____ Other: _____	
<input type="checkbox"/> Osteoporosis: _____	
Lifestyle and Dietary Factors:	
<input type="checkbox"/> Occupation Stress Level: _____ Low / Medium / High	
<input type="checkbox"/> Energy Level: _____ Low / Medium / High	
<input type="checkbox"/> Caffeine Intake/Daily: _____	<input type="checkbox"/> Alcohol Intake/Weekly: _____
<input type="checkbox"/> Colds per Year: _____	<input type="checkbox"/> Anemia: _____
<input type="checkbox"/> Gastrointestinal Disorder: _____	
<input type="checkbox"/> Hypoglycemia: _____	
<input type="checkbox"/> Thyroid Disorder: _____	
<input type="checkbox"/> Pre/Postnatal: _____	
Cardiovascular:	
<input type="checkbox"/> High Blood Pressure: _____	<input type="checkbox"/> Hypertension: _____
<input type="checkbox"/> High Cholesterol: _____	
<input type="checkbox"/> Hyperlipidemia: _____	
<input type="checkbox"/> Heart Disease: _____	
<input type="checkbox"/> Heart Attack: _____	<input type="checkbox"/> Stroke: _____
<input type="checkbox"/> Angina _____	<input type="checkbox"/> 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.

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\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date