HEALTH HISTORY QUESTIONNAIRE

Today's Date: __________
Name _____________________________________ **Date of Birth:** _________________
Address ____
Primary Phone # ___________________ **Additional Phone #:** ___________________
E-Mail Address ______________________

Emergency Contact:
Name ____ **Relation** _________________
Phone Number ________________________

Check any of the following which apply to **<u>you</u>**:

( ) Heart problems
( ) Chest Pain
( ) Shortness of breath at rest
( ) Fainting or dizzy spells
( ) High blood pressure
( ) Seizures/convulsions
( ) Diabetes
( ) Lower back pain
( ) Anemia
( ) Allergies
( ) Asthma
( ) Arthritis
( ) High cholesterol
( ) Smoker/Quit within the last 6 months
( ) Pregnant/Or in the last 3 months

Are you on any **medication(s)?**
If YES, please list them:____
____

Have you ever injured your:

___ Knees	Right/Left	How:	When:
___ Ankles	Right/left	How:	When:
___ Hips	Right/left	How:	When:
___ Shoulders	Right/left	How:	When:
___ Elbows	Right/left	How:	When:
___ Wrists	Right/left	How:	When:

If you answered yes to any of the above, with what activities do you experience pain?
____
____

Rate your pain on a scale of 1 to 10. One being almost nonexistent and 10 being excruciating:____

Have you ever injured your back or neck?_______________________________________
If YES, how?____

With what activities do you experience pain in the back or neck?___________________
____

Rate your pain on a scale of 1 to 10. One being almost nonexistent and 10 being excruciating:____

Do you have any other physical limitations which should be considered before you undertake an exercise program? ____
____

What is the present state of your general health?
____

What regular physical activities do you do now?
____
How often? ___________________________ How long is each session? ______________

I, ____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that this information is being provided as part of my initial consultation and may not be periodically updated. I assume the risk for any changes in my medical condition that might affect my ability to exercise.
I acknowledge that I have read the foregoing statements and understand the content thereof. Any questions I had were answered to my full satisfaction.

____ __________________________
Signature Date

THANK YOU FOR YOUR COMPLETE AND HONEST RESPONSES.