

HEALTH AND FITNESS HISTORY

Date: _____

Name: _____

Occupation: _____

Height: _____ Weight: _____ Age: _____ Date of Birth: _____

Please check as appropriate and provide details as necessary. Any information you wish to provide is helpful. All information is confidential.

Y N

___ ___ Arthritis ___ Rheumatoid ___ Osteo

___ ___ Cancer

___ ___ Tuberculosis

___ ___ Kidney disease

___ ___ Lung disease

___ ___ Digestive upsets

___ ___ Neurological problems

___ ___ Heart disease

___ ___ Epilepsy

___ ___ Abdominal pain

___ ___ TMJ

___ ___ Diabetes

___ ___ Headaches

___ ___ Sinusitis

___ ___ Fatigue: time of day _____

Y N

___ ___ Constipation

___ ___ High or low blood pressure

___ ___ Frequent colds or flu

___ ___ Painful feet

___ ___ Varicose veins or phlebitis

___ ___ Anxiety

___ ___ Depression

___ ___ Hernia or rupture

___ ___ Allergies

___ ___ Chest pain

___ ___ Contact lenses

___ ___ Nicotine daily avg. _____

___ ___ Alcohol daily avg. _____

___ ___ Pregnant

___ ___ PMS

Are you under the care of a medical practitioner? (MD, chiropractor, naturopath, psychologist, etc.) If yes, please explain your condition.

List any medications you are using and their purposes.

Have you been hospitalized or had surgery in the past five years? Please explain.

Do you currently have any infectious conditions or diseases? Please explain.

Please describe any skin conditions you currently have. (rashes, athlete's foot, eczema, etc)

Is there anything relating to your health which you are concerned about? Specific pains?

Please describe your history of accidents, injury, pain, soreness, stiffness, immobility, etc., (include whiplash, scoliosis, broken bones, etc.) affecting the following areas:

Cervical spine and head (neck, head)

Thoracic spine (upper, mid back)

Lumbar spine (lower back)

Sacrum and hips

Joints (elbows, shoulders, ankles, knees, etc. - sprains, bursitis, swelling)

Extremities (legs, arms - breaks, sciatica, carpal tunnel)

Other

Please describe any significant accidents, diseases, or ailments which you have experienced in the past five years that are not included above.

Relationships. Mother alive? _____ Father alive? _____

Describe the significant relationships in your life:

Sleep. Average hours of sleep per night _____ On rising: Refreshed ___ Tired ___

Type of Exercise _____

Hours per day (avg.) _____ Hours per week (avg.) _____

Please describe your diet:

How is your health preventing you from doing what you want to do with your life?

Is there anything you wish to add?