



Detailed Health History Questionnaire

Name _____ Date _____

Statement of Health:

1. When was the last time you saw your doctor? _____
2. Why did you seek your doctor's advice? _____
3. Are you currently taking any medications? Yes No
 - a. Explain

4. Has your doctor ever told you that you have a bone or joint problem such as arthritis which could be aggravated by exercise or might be made worse by exercise? Yes No
5. Have you had surgery in the last 6 months? Yes No
If so, what? _____
6. Do you have any medical conditions? Yes No
If so, what?

7. Have you ever seen a chiropractor, acupuncturist, or other alternative medicine practitioner? Yes No
8. Have you ever experienced any of the following symptoms: Circle **Yes or No**
 - a. Pain or discomfort in the chest Yes No
 - b. Unaccustomed shortness of breath Yes No
 - c. Dizziness Yes No

- d. Labored or uncomfortable breathing with or without pain Yes No
 - e. Swollen ankles Yes No
 - f. Heart Palpitations Yes No
 - g. Heart Murmur Yes No
 - h. Asthma Yes No
 - i. Fatigue and/or drowsiness Yes No
 - j. Headaches Yes No
 - k. Digestive difficulties Yes No
 - l. Trouble sleeping Yes No
9. Do you drink several cups of coffee a day to keep you going? Yes No
10. Do you have high blood pressure? If yes what is your current blood pressure w/o medication? _____
11. Are you taking any medication for hypertension?
If so, what _____
12. When was the last time you had your cholesterol checked? _____
13. Is your cholesterol over 240? Yes No
14. Do you smoke? Yes No
15. Have you ever smoked? Yes No If so, when did you quit _____
16. Do you have diabetes? Yes No
17. Do you have a family member who has had coronary or atherosclerotic disease prior to age 55? Yes No
18. Do you or have you ever had pain or discomfort in this following areas:
Circle Y or N & R or L
- a. Back Yes No Cause _____
 - b. Knee Yes No Right Left Cause _____
 - c. Shoulder Yes No Right Left Cause _____
 - d. Elbow Yes No Right Left Cause _____
 - e. Wrist Yes No Right Left Cause _____
 - f. Ankle Yes No Right Left Cause _____
 - g. Torn Ligaments or cartilage in the knee Yes No Right Left
19. Have you ever had a neck injury such as whiplash? _____
20. Have you ever been treated for spinal disc injury? _____

21. Do you ever experience tingling or numbness in your elbows or hands?

Diet/Nutrition:

22. Do you eat foods high in fiber such as whole grain bread, cereal or fresh fruits and veggies each day? Yes No

23. Do you eat foods high in fat and cholesterol, such as fatty meat, cheese, fried foods or eggs each day? Yes No

24. How many meals do you eat each day? _____

25. Do you eat breakfast everyday? Yes No

26. What is your daily caloric intake? _____

27. Do you crave sugar? Yes No

28. Are you currently taking nutritional supplements? Yes No If so, what kind? _____

29. Is there any reason why you can not exercise? Yes No

30. In an average week how often do you exercise _____#days _____ min/hour

31. How long have you been exercising? _____weeks/months/years

32. What kind of exercise do you do?

33. Have you ever participated in a diet and/or nutrition program before Yes No

If so, please explain _____

34. Did you achieve your goal? Yes No

a. Was it permanent? Yes No

35. What are your desired goals now?

36. How do you expect to achieve these goals?

37. What, if any, obstacles might prevent you from achieving your goals?

38. How would you rate your overall health? _____

Please list any other concerns you may have

I, _____, certify that I understand the foregoing questions and my answers are true and complete. I also understand 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.

If you answered “Yes” to one or more questions and have not recently done so, consult with you doctor before beginning an exercise program. Tell your doctor which questions you answered yes to and explain you plan to undergo an exercise program that may include, but not limited to, weight and/or resistance training. After medical evaluation, ask you doctor which activities you may safely participate in and what specific restrictions if any should apply to your condition and what activities and/or exercises you should avoid.

I, _____, acknowledge that I have read the foregoing statement and understand the content thereof.

Signature

Date