HEALTH AND FITNESS HISTORY

Today's date_____

Name & Pronouns: _____

Occupation _____

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		Y	N	
___	___	Arthritis ___ Rheumatoid___Osteoporosis	___	___	Constipation
___	___	Cancer	___	___	High or low blood pressure
___	___	Tuberculosis	___	___	Frequent colds or flu
___	___	Kidney disease	___	___	Painful feet
___	___	Lung disease	___	___	Varicose veins or phlebitis
___	___	Digestive upsets	___	___	Anxiety
___	___	Neurological problems	___	___	Depression
___	___	Heart disease	___	___	Hernia or rupture
___	___	Epilepsy	___	___	Allergies
___	___	Abdominal pain	___	___	Chest pain
___	___	TMJ	___	___	Contact lenses
___	___	Diabetes	___	___	Nicotine daily avg. _____
___	___	Headaches	___	___	Pregnant
___	___	Sinusitis	___	___	PMS
___	___	Fatigue: time of day_____			

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, athletes 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?