Client Info/Health/Medical Questionnaire

Name:_____D.O.B:_____Age:_____

Address/ Street: _____City: _____State:_____Zip:_____

Home Phone:_____Cell:_____ _____Work:_____

Email:_____Sports:_____Positions:_____

Preferred Type of Training:_____Preferred Training Days:_____

Occupation:_____Work Hazards:_____

Emergency Contact:_____Phone:_____Relationship:_____Email:_____

Physician Name:_____ Office:_____Specialty:_____

Physician Phone:_____Physician Fax:_____Physician E-mail:_____

Are you currently under the care of a physician for any reason at all?_____ If yes, please explain:_____
_____

Does your physician know that you are beginning an exercise program?_____ If yes, are you medically cleared to participate? If no, please explain:_____

CurrentHealthProblems:_____
_____

Do you know of any physical condition that you have that could be aggravated by exercising or exerting yourself? If yes, please explain:_____
_____

Current Medications: (Prescription or over the counter)_____
_____

Are you currently taking any medication that could cause a reaction while exercising? _____If yes, please explain
_____

Diagnostics / Labaratory Procedures Performed/Results: (e.g. X-rays, MRI, CT scan)_____
_____

Major Injuries, Surgeries and Hospitalization:(Please list all injuries, surgeries, complications if any)

Year	Injuries/Surgery/Illness	Outcome
_____	_____	_____
_____	_____	_____

What types of therapies have you tried for these problem(s) or to improve your overall health?

_____Physical Therapy _____Accupuncture _____Chiropractic ____Medication
_____Diet Modification _____Vitamins/Minerals _____Herbs ____Fasting
_____Homeopathy _____Herbs _____Other

Do you experience any of these general symptoms EVERY DAY?

_____Debilitating Fatigue _____Headaches _____Diarrhea
_____Depression _____Dizziness _____Constipation
_____Disinterest in eating _____Insomnia _____Inflammation
_____Shortness of Breath _____Nausea _____Itching/Rash
_____Panic Attacks _____Vomiting _____Double Vision
_____Pain (0-10): Circle 0 1 2 3 4 5 6 7 8 9 10 Location:_____

Circle the level of stress you are experiencing on a scale of 0-10: (0 = lowest, 10=Highest)

0 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g. work, school, residence, finances, legal problems):_____
_____

Do you consider yourself:_____Underweight _____Overweight _____Appropriate Weight

Have you had unintentional weight loss/gain of 10 lbs. or more in the last 3 months?_____
Do you smoke cigarettes?_____If yes, how many packs/day?_____For how long?_____

Current Health Goals:_____
_____
_____

Health Habits

_____Tobacco:
Cigarettes: #/day_____
Cigars:#/day_____

_____Alcohol:
Wine: #glasses/week
Liquor: # oz/week
Beer: #glasses/week

_____Caffeine:
Coffee: #6oz cups/day_____
Tea: #6oz cups/day_____
Soda: #12oz cans/day_____
Other:_____

_____Water: #8oz glasses/day

Exercise

_____5-7days/week
_____3-4 days/week
_____1-2 days/week
_____45 min or more duration/workout
_____30-45 min duration/workout
_____less than 30 min/workout
_____Walk: #days/week
_____Run/Jog
_____Swimming
_____Cycling
_____Other Aerobic exercise
_____Stretch # days/week
_____Stretch duration/session
_____Weight lifting
_____Other:_____

Medical History

_____Arthritis
_____Allergies/Hay Fever
_____Asthma
_____Alcoholism
_____Autoimmune Disease
_____Blood Pressure Problems
_____Bronchitis
_____Cancer (Type)_____
_____Chronic Fatigue Syndrome
_____Carpal Tunnel Syndrome
_____Cholesterol
_____Circulatory Problems
_____Colitis/IBD
_____Dental Problems
_____Pneumonia
_____Seasonal Affective Disorder
_____ Skin Problems
_____Depression
_____Diabetes
_____Diverticular Disease
_____Drug Addiction
_____Eating Disorder
_____Epilepsy
_____Emphysema
_____Eyes, ears, throat problems
_____Environmental Sensitivities
_____Fibromyalgia
_____Food Intolerance
_____Gastroesophageal Reflux Disease
_____Genetic Disorder
_____Glacoma
_____Tuberculosis
_____Ulcer
_____Urinary Tract Infection
_____Gout
_____Heart Disease
_____Infection, Chronic
_____Irritable Bowel Syndrome
_____Kidney/Bladder Disease
_____Liver/Gallbladder
_____Mental Illness
_____Migraine Headaches
_____Neurological Disorder
_____Sinus Problems
_____Stroke
_____Thyroid condition
_____Obesity
_____Osteoporosis
_____Varicose Veins
_____Other:_____
_____Other:_____

Family Health History
_____Arthritis
_____Asthma
_____Cancer
_____Depression
_____Diabetes
_____Drug Addiction
_____Eating Disorder
_____Genetic Disorder
_____Glaucoma
_____Heart Disease
_____Infertility
_____Learning Disability
_____Mental Illness
_____Migraine Headaches
_____Neurological Disorders
_____Obesity
_____Osteoporosis
_____Stroke
_____Suicide
_____Other:_____

Medical (Men)
_____Benign Prostatic Hyperplasia
_____Prostate Cancer
_____Other:_____

Medical (Women)
_____Menstrual Irregularities
_____Endometriosis
_____Infertility
_____Fibrocystic Breasts
_____ Ovarian Cysts
_____Premenstrual Syndrome
_____Breast Cancer
_____Pelvic Inflammatory Disease
_____Vaginal Infections
_____Other:_____
_____Birth Control:_____
___Surgical Menopause
___Menopause