HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your answers are confidential.

PERSONAL INFORMATION

Name:_____ Date of birth:_____ Age:_____

Phone: _____ Alternate Phone: _____

Email: _____

In case of emergency please notify:

Name:_____ Relationship:_____

Phone: _____

MEDICAL INFORMATION

Are you under the care of a physician, chiropractor or other health care professional for any reason?

☐ Yes ☐ No

If yes, list reason:_____

_____

Are you taking any medications? ☐ Yes ☐ No

Type	Dosage/Frequency	Reason for taking

Please list any allergies: _____

_____

Has your doctor ever said your blood pressure was too high? ☐ Yes ☐ No

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?

☐ Yes ☐ No

Is there any reason not mentioned here why you should not follow a regular exercise program?

If so, please explain:_____

Do you smoke? ☐ Yes ☐ No

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain or general discomfort:

Head / Neck:_____

Upper Back:_____

Shoulder / Clavicle:_____

Arm / Elbow:_____

Wrist / Hand:_____

Lower Back:_____

Hip / Pelvis:_____

Thigh / Knee:_____

Arthritis:_____

Hernia:_____

Surgeries:_____

Other:_____