



Health History

Print your answers. Please print clearly.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip		
Home Phone:	Work Phone:	

Physician Information

Current Physician:	Phone:		
Are you under the care of a physician, chiropractor, or other health care professional for any reason (circle)? If yes, list reason:		Yes	No
Are you taking any medications? <i>(If yes, please list)</i> Medication: Dosage/Frequency: Condition:		Yes	No
List any and all allergies:			
Has your doctor ever diagnosed you with high blood pressure?		Yes	No
Has your doctor ever diagnosed you with a bone or joint problem that has been or could be made worse by exercise?		Yes	No
Are you over 65 years of age?		Yes	No
Are you used to vigorous exercise?		Yes	No



Questionnaire: Health History

MEDICAL INFORMATION, CONTINUED

Is there any reason not mentioned why you should not follow a regular exercise program? _____ Yes _____ No
If yes, please explain: _____

Have you recently experienced any chest pain associated with either exercise or stress? _____ Yes _____ No
If yes, please explain: _____

SMOKING

Please check the box that describes your current habits:

- Non-user or former user; Date quit: _____
- Cigar and/or pipe
- 15 or less cigarettes per day
- 16 to 25 cigarettes per day
- 26 to 35 cigarettes per day
- More than 35 cigarettes per day

If there is family history for any condition, please check the box to the left. On the line to the right, please designate who in the family has or had this condition.

- Asthma: _____
- Respiratory/Pulmonary Conditions: _____
- Diabetes: Type I: _____ Type II: _____ How Long? _____ -
- Epilepsy: Petite Mal: _____ Grand Mal: _____ Other: _____ -
- Osteoporosis: _____ -

LIFESTYLE AND DIETARY FACTORS

Please fill in the information below (circle one):

- Occupational Stress Level: Low / Medium / High
- Energy Level: Low / Medium / High
- Caffeine Yes / No
- Alcohol Yes / No
- Anemia Yes / No
- Gastrointestinal Disorder: Yes / No
- Hypoglycemia: Yes / No
- Thyroid Disorder: Yes / No
- Pre/Postnatal: Yes / No

CARDIOVASCULAR

Please fill in the information below (circle one):

High Blood Pressure: Yes / No Hypertension: Yes / No

High Cholesterol: Yes / No

Hyperlipidemia: Yes / No

Heart Disease: Yes / No

Heart Attack: Yes / No

Stroke: Yes / No

Angina: Yes / No

Gout: Yes / No



Questionnaire: Health History

Pain History

Check if you have or have had pain in the following. If yes, please describe:

- Head/Neck: _____
- Upper Back: _____
- Shoulder/Clavicle: _____
- Arm/Elbow: _____
- Wrist/Hand: _____
- Lower Back: _____
- Hip/Pelvis: _____
- Thigh/Knee: _____
- Arthritis: _____
- Hernia: _____
- Surgeries: _____
- Other: _____

Nutrition

Are you on any specific food/diet plan? If yes,
please list and advise who prescribed it:

Yes No

Do you take dietary supplements?
If yes, please list:

Yes No

Do you notice your weight fluctuating?

Yes No

Have you experienced a recent weight gain or loss?
If yes, explain how:

Yes No

Over what amount of time?

How many beverages do you consume per day that contain caffeine? What are they?

How would you describe your current nutritional behaviors?

Other food/nutritional issues you want to include (*food allergies, mealtimes, etc.*)



Questionnaire: Health History

Work and Environment

Please check the box that best describes your work and exercise Habits.

- Intense occupational and recreational effort
- Moderate occupational and recreational effort
- Sedentary occupational and intense recreational effort
- Sedentary occupational and moderate recreational effort
- Sedentary occupational and light recreational effort
- Complete lack of activity

How stressful are your environments (circle one)?

Work:	Minimal	Moderate	Average	Extremely
Home:	Minimal	Moderate	Average	Extremely

Do you work more than 40 hours a week?

Yes No

Anything else you would like your nutrition coach to know?

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

SIGNATURE OF PARENT: _____
or GUARDIAN (for participants under the age of 18)

WITNESS: _____