



Health History Questionnaire

Name _____ Date _____

Street address _____ City/State/Zip _____

Phone (home) _____ (work) _____

Email address _____ (cell phone number) _____

Date of birth _____

Person to contact in case of emergency:

Name _____ Phone _____

For most people, physical activity should not pose any problem or hazard. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check the "Yes" or "No" response opposite the question if it applies to you.

Yes No

- | | | |
|-------|-------|---|
| _____ | _____ | 1. Are you over age 55 and/or not accustomed to vigorous exercise? |
| _____ | _____ | 2. Are you or have you ever been a diabetic? |
| _____ | _____ | 3. Are you now pregnant, or have you been pregnant within the last 3 months? |
| _____ | _____ | 4. Have you had any surgery in the last 3 months? |
| _____ | _____ | 5. Have you been hospitalized in the last 2 years? If so, when and why? |
| _____ | | |
| _____ | _____ | 6. Have you ever seen a chiropractor, acupuncturist, or other alternative medicine practitioner? If so, when and why? |

Please check the box if you have ever experienced any of the following symptoms:

When first experienced

Treatment used

- | | | |
|--|-------|-------|
| <input type="checkbox"/> Pain or discomfort in the chest | _____ | _____ |
| <input type="checkbox"/> Unaccustomed shortness of breath | _____ | _____ |
| <input type="checkbox"/> Dizziness | _____ | _____ |
| <input type="checkbox"/> Labored or uncomfortable breathing,
with or without pain | _____ | _____ |
| <input type="checkbox"/> Swollen ankles | _____ | _____ |
| <input type="checkbox"/> Heart palpitations | _____ | _____ |
| <input type="checkbox"/> Heart murmur | _____ | _____ |
| <input type="checkbox"/> Limping | _____ | _____ |

☐ Yes ☐ No Do you have high blood pressure? If yes, what is your current blood pressure without medication? _____

☐ Yes ☐ No Is your total serum cholesterol level over 220?

☐ Yes ☐ No Do you smoke?

☐ Yes ☐ No Have you ever smoked? If so, when did you quit?

☐ Yes ☐ No Do you have diabetes?

☐ Yes ☐ No Do you have a family member who has had coronary or atherosclerotic disease before age 55?

☐ Yes ☐ No Do you have pain or discomfort in your back?

☐ Yes ☐ No Do you have pain or discomfort in your knee? If so, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your shoulder? If so, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your elbow? If so, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your wrist? If so, ☐ right or ☐ left?

☐ Yes ☐ No Do you have pain or discomfort in your ankle? If so, ☐ right or ☐ left?

If you checked "Yes" above, please describe your pain. On a scale of 1 to 10, with 1 being almost nonexistent and 10 being excruciating, how severe is it? Does it get more or less severe as the day goes on? When do you notice it? What really aggravates it?

☐ Yes ☐ No Have you ever torn ligaments or cartilage in your knee? If so, when? _____

☐ Yes ☐ No Did you have surgery on this knee? If so, when? _____

☐ Yes ☐ No Have you ever dislocated your shoulder? If so, when? _____

☐ Yes ☐ No Have you ever had shoulder surgery? If so, which shoulder? When? _____

☐ Yes ☐ No Have you ever had a neck injury, such as whiplash? If so, when? _____

☐ Yes ☐ No Have you ever been treated for a spinal disk injury? If so, when? _____

☐ Yes ☐ No Do you ever experience tingling or numbness in your elbows or hands? _____

What is the present state of your general health? _____

I certify that I understand the foregoing questions and my answers are true and complete. I also understand that this information is being provided as part of my initial consultation and may or may not be periodically updated.

I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Signature

Date

Printed Name

If you answered yes to one or more questions and you have not recently consulted with your doctor, do so before beginning an exercise program. Tell your doctor which questions you answered yes to and explain that you plan to undergo an exercise program that may include, but may not be limited to, weight and/or resistance training and cardiovascular conditioning. After medical evaluation, ask your doctor

1. which activities you may safely participate in, and
2. what specific restrictions, if any, should apply to your condition and which activities and/or exercises you should avoid.

I acknowledge that I have read the foregoing statements and understand the content thereof.

Signature

Date

Printed Name