Sports Therapy & Wellness

Health History Questionnaire

Health History Questionnaire

ANSWER EACH QUESTION BY PRINTING THE NECESSARY INFORMATION. YOUR ANSWERS ARE CONFIDENTIAL.

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Cell Phone: _____

Occupation: _____ Employer: _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

ADDITIONAL INFORMATION

_____
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NUTRITIONAL INFORMATION

Are you on any specific food/diet plan at this time? ☐ Yes ☐ No
If yes, please list:

Do you take any dietary supplements? ☐ Yes ☐ No
If yes, please list:

Do you experience frequent weight fluctuations? ☐ Yes ☐ No

Have you experienced a recent weight gain or loss? ☐ Yes ☐ No
If yes, list change:

Over how long?

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

How would you describe your current nutritional habits?

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

What foods do you like to eat:

Morning Foods:

Lunch Foods:

Snack Foods:

Dinner Foods:

FAMILY AND PERSONAL MEDICAL HISTORY

Physician: _____ Phone: _____

Are you under the care of a physician, chiropractor, or other health care professional for any reason? ☐ Yes ☐ No

If yes, list reason:

If there is family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

☐ 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:

☐ Occupational Stress Level: ☐ Low/ ☐ Medium/ ☐ High

☐ Energy Level: ☐ Low/ ☐ Medium/ ☐ High

☐ Caffeine Intake Daily: _____ ☐ Alcohol Intake/Weekly: _____

☐ Colds Per Year: _____ ☐ Anemia: _____

☐ Gastrointestinal Disorder: _____

☐ Hypoglycemia: _____

☐ Thyroid Disorder: _____

☐ Pre/Postnatal: _____

CARDIOVASCULAR

Please fill in the information below:

☐ High Blood Pressure: _____ ☐ Hypertension: _____

☐ High Cholesterol: _____

☐ Hyperlipidemia: _____

☐ Heart Disease: _____

☐ Heart Attack: _____ ☐ Stroke: _____

☐ Angina: _____ ☐ Gout: _____

MUSCULOSKELETAL INFORMATION

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: _____

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

Are you over the age of 65? ☐ Yes ☐ No

Are you unaccustomed to vigorous exercise? ☐ Yes ☐ No

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:

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SMOKING

Please check the box that describes your current habits:

- ☐ Non-user or former user; Date quit: _____
- ☐ Cigar and/or pipe
- ☐ 10 or less cigarettes per day
- ☐ 10 or more cigarettes per day

WORK AND EXERCISE HABITS

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

- ☐ Intense occupational and recreational exertion
- ☐ Moderate occupational and recreational exertion
- ☐ Sedentary occupational and intense recreational exertion
- ☐ Sedentary occupational and moderate recreational exertion
- ☐ Sedentary occupational and light recreational exertion
- ☐ Complete lack of all exertion

To what degree do you perceive your environment as stressful?

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

Do you work more than 40 hours a week? ☐ Yes ☐ No

Please make any other comments you feel are pertinent to your exercise program.

Informed Consent Form

I, (print name) _____, give my consent to participate in the physical fitness evaluation program conducted by Complete Body Balance Inc.

Benefits
Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

Risks
I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

Testing and Evaluation Results
I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, body composition and potentially a physical range of motion and baseline strength assessment.

I further understand that such screening is intended to provide Elite Sports Therapy and Wellness and Complete Body Balance Inc. with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at Complete Body Balance Inc., and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

Print Name: _____

Signature: _____ Date: _____

Parent or guardian Signature: _____
(for participants under the age of 18)

PRACTITIONER NOTES:_____