Get Out of Back Pain

HEALTH HISTORY QUESTIONNAIRE

Name____ Age________ Sex_______ Today's Date___________________________

Address_______________________________________ Home Phone__________________ Cell or Work Phone_____________________

City____ State______ Zip ____________ Height_____________ Weight______________

Date of Birth ______________________ Occupation______________________________________ _______ Are you pregnant? Yes No

How did you hear about us?____

Known Diagnosis if any____ ____________

How and when did this condition start?____

What else have you done to treat this condition?____

What success if any have you had with other treatments? Please be specific as to what worked and what did not work

____

____

Do you consider yourself: □ underweight □ overweight □ just right Your weight a year ago______________

Do you exercise? Yes No If Yes, type of exercise_______________# times/wk or month_____________Duration_____________________

Other type of exercise______________________________# times/wk or month____________________ Duration____________________

Do you smoke? Yes No If Yes, what (cigarettes, pipe, pot)_____________________________#/day or week_________________________

Do you drink alcohol? Yes No If Yes, what (beer, wine, liquor)___________________________#/day or week______________________

Do you drink coffee or tea? Yes No If Yes, what (coffee, decaf, black tea)_________________________Cups/day__________________

Do you drink soft drinks? Yes No If Yes, what (cola, sugar-free)_________________________________#/week____________________

Do you drink water? Yes No If Yes, what (tap, filtered)__________________________________ Glasses/day______________________

Are you dieting? Yes No If Yes, type of diet________________________________How long on this diet?__________________________

What are your eating habits?____

Do you have any known food allergies? Yes No If Yes, to what____

List current health problems for which you are being treated____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Are you taking any medications (prescriptions or over-the-counter)? Please specify what and dosage: ________________________________

____

Are you taking any supplements? Please specity____

Date of last physical exam: _____________Practitioner name ______________________________ Phone Number ____________________

Please indicate if you have or have had any of the following:

Past	Present		Past	Present		Past	Present		Past	Present	
□	□	Alcoholism	□	□	Allergies	□	□	Arthritis	□	□	Asthma
□	□	Back Condition	□	□	Bursitis	□	□	Carpal Tunnel	□	□	Diabetes
□	□	Drug Addiction	□	□	Eating Disorder	□	□	Environmental Sensitivities	□	□	Epilepsy
□	□	Fatigue	□	□	Fibromyalgia	□	□	Heart Trouble (any)	□	□	Heart Condition
□	□	Hernia	□	□	High Blood Pressure	□	□	Low Blood Pressure	□	□	Joint Pain
□	□	Migraine	□	□	Nervous Tension	□	□	Osteoporosis	□	□	Sciatica
□	□	Shortness of Breath	□	□	Sinus	□	□	Tight Shoulders	□	□	Ulcers
□	□	Varicose Veins									

□ □ Autoimmune Issues, please specificy____

□ □ Other____ □ □ Other____

I certify to the best of my knowledge the above information is correct and complete. I also understand that Dot Spaet assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. All individuals are strongly encouraged to consult
with a physician before entering a non-medically supervised exercise program.

Signature____Date_____________________________________

Signature of Fitness Coach____Date_____________________________________

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