

Get Out of Back Pain

HEALTH HISTORY QUESTIONNAIRE

Addre							_ ~	Sex Today's Date				
	ess					ne		Cell or Work Ph	none_			
City_					State	_ Zip _		Height		Weig	ht	
	-											
		•						what worked and what did n		k		
								ır weight a year ago				
-								vk or monthD				
Other type of exercise									Ouration			
Do yo	u sm	oke? Yes No If Yes	s, what (cigarettes, pip	e, pot)			#/day or we	eek			
Do yo	u drir	nk alcohol? Yes No	If Yes,	what (beer, w	ine, liquor)			#/day or w	eek			
Do yo	u drir	nk coffee or tea? Yes	No If	Yes, what (co	offee, decaf, b	lack tea)		C	ups/da	ay		
Do yo	u drir	nk soft drinks? Yes N	lo If Y	es, what (cola	, sugar-free)_			#	/week			
Do yo	u drir	nk water? Yes No	If Yes, w	hat (tap, filtere	ed)			Glasses/da	y			
Are yo	ou die	eting? Yes No If Ye	s, type c	f diet				How long on this diet?_				
What	are y	our eating nabits?										
	•											
Do yo	u hav	ve any known food alle	gies? Y	es No If Ye	s, to what							
Do yo List cı	ou hav	ve any known food aller t health problems for w	gies? Y	es No If Yea	s, to what uted							
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