# GYM

## Health History Questionnaire

*Please complete and bring with you to your initial assessment.*

All information is strictly confidential.
Please fill out the forms accurately and completely.

Name: _____ Date: _____/_____/____

Address (street, city, state and zip please): _____

Date of Birth: _____/_____/____ ¤ mail invoice ¤ email invoice

Home Phone:_____ Cell Phone:_____ email:_____

Contact Preference: ¤ home phone ¤ cell phone ¤ text message ¤ email

Occupation/Place of Business:_____ phone: _____

Emergency Contact:_____ phone: _____

Referred By: _____

Please list the other practitioners you are currently seeing and their location:

Physician: _____ phone: _____

Physician: _____ phone: _____

Physician: _____ phone: _____

Chiropractor: _____ phone: _____

Physical Therapist: _____ phone: _____

Massage Therapist: _____ phone: _____

Other: _____ phone: _____

I, _____, have read and understand the policies of GYM.
Please print name here

Health Questionnaire:

1) Please list any orthopedic conditions or injuries that you currently have or have had in the past. These may include back, neck, shoulder, elbow or other bone, joint, or muscular problems including osteoporosis & arthritis. Please indicate left or right and the year the injury happened.

_____
_____
_____

Do you have pain or limited mobility from this injury/condition? Please describe.

_____
_____
_____

2) Please list any cardiac or respiratory conditions that you currently have or have experienced in the past. These may include heart attack, irregular heartbeat or palpitations, chest pain or angina, asthma, COPD, or high blood pressure.

_____
_____
_____

Have you been diagnosed and are you currently being treated? What are your practitioner's recommendation or limitations for exercise?

_____
_____
_____

3) Please list any neurological conditions that you currently have or have experienced in the past. These may include headaches, stroke, and severe dizziness or fainting, head injury such as concussion, or seizures.

_____
_____
_____

Have you been diagnosed and are you currently being treated? What are your practitioner's recommendation or limitations for exercise? Do you have pain or limited mobility from this injury/condition? Please describe.

_____
_____
_____

4) Please list any stomach, intestinal, or eating problems or conditions that you currently have or have experienced in the past. These may include irritable bowel syndrome, Crohn's disease, anorexia, bulimia, constipation, or stomach pain. Have you been diagnosed and are you currently being treated?

_____
_____

5) Do you have Diabetes? ¤ yes ¤ no
If yes, when were you diagnosed with Diabetes? _____

Do you feel you are controlling your Diabetes?
_____
_____

6) Do you have any other medical or health conditions that were not already listed or discussed?
_____
_____
_____

7) Do you have chronic pain? ¤ yes ¤ no

If yes, please give location & description of pain.
_____
_____
_____

On a scale of 0-10, how would you rate your current pain? _____
*(0= no pain, 10 = worst pain of your life)*

8) Please list all prescription or non-prescription medications you take. These include over-the-counter medications, vitamins, and herbal supplements.

| Medication | Reason |
|---|---|
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| | |

Do any of these medications impact your ability to exercise? If yes, please explain.
_____
_____
_____

9) Do you smoke? ¤ yes ¤ no
If yes, how much do you smoke per day? _____

10) Do you drink alcohol? ¤ yes ¤ no
If yes, how many glasses or drinks per week? _____

11) How many hours of sleep do you normally sleep?_____

How many hours of sleep do you feel your best with?_____

12) On a scale of 1-10, how would you rate your current stress level? _____

*(1 = very low, 10 = very high)*

13) Throughout a normal day, would you describe your normal activity as:

¤Sedentary ¤ Light Activity ¤ Moderate Activity ¤ Heavy Activity

14) Do you currently exercise? ¤ yes ¤ no

How often do you exercise per week? _____

How long do you exercise at a time? _____

What is your current exercise routine or what activities do you currently do?

_____

_____

_____

15) What do you consider an excellent outcome for an exercise/wellness program?

1._____
2._____
3._____
4._____

16) On a scale of 1-10, how would you rate your current health? _____

*(1= low, 10 = high)*

17) On a scale of 1-10, how would you rate your current nutrition? _____

*(1= low, 10 = high)*

How many times a day do you eat? _____ Do you skip meals? ¤ yes ¤ no

How many glasses of water do you consume daily? _____

How many caffeinated beverages do you consumer per day (coffee, soda, other)? _____

Does your energy drop during the day? ¤ yes ¤ no

If yes, when? _____

How many times per week do you eat out and where do you usually go?

_____

_____

_____