CLIENT HEALTH HISTORY

Name:_____Date:_____

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question or require assistance, please speak with your trainer/therapist. Thank you.

GENERAL HEALTH

How would you rate your general health?

O Excellent O Good O Average O Fair O Poor

Do you smoke: O Yes, ___packs/day O No O Quit

What is your stress level? O Low O Medium O High

How many hours of sleep do you get per night?_____

EXERCISE

How often do you exercise outside of normal daily activities?

O none O < 1x/wk O 1-2x/wk O 3-5x/wk O 6-7x/wk

Do you exercise less than you would like? Yes / No

If yes, why? O Illness O Injury O Time O Other

Which physical activities interest you?_____

_____

What are the best days and times for you to exercise?

O Mon O Tues O Wed O Thurs O Fri O Sat O Sun

O Early morning (before 9am) O Morning (9am-Noon)

O Early Afternoon (Noon-3pm) O Late Afternoon (3-6pm)

O Evening (after 6pm)

MEDICATION

Please list all medications (prescription and over-the-counter) you are currently taking:_____

_____

_____

_____

NUTRITION

What does a typical day of food look like for you?

Breakfast:_____

O Don't eat Time:_____

Lunch:_____

O Don't eat Time:_____

Dinner:_____

O Don't eat Time:_____

Snacks:_____

O Don't eat Time:_____

Food allergies or diet restrictions:_____

WORK HISTORY

Occupation:_____

Work Status: O Unemployed O Student

O Full-time O Homemaker O Retired

O Part-time O Modified duty

Physical activities at work (check all that apply):

O sitting O lifting – heavy / repetitive

O standing O heavy equipment operation

O phone use O driving

O computer use O climbing

O other:_____

MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

O Cancer O Heart problems

O Depression O High blood pressure

O Stroke O Lung problems

O Kidney problems O Blood disorders

O Thyroid problems O Epilepsy / seizures

O Diabetes O Allergies

O Multiple sclerosis O Head injury

O Arthritis – osteo O Osteoporosis

O Rheumatoid arthritis O Broken bone

O Stomach problems O Poor circulation

O Parkinson's disease O Swelling

O Infectious disease O Other:_____

O Pregnancy _____

Please list any recent/relevant past surgeries:_____

_____

_____

_____

GOALS

What are your reasons for coming to see us?

O Lose Body Fat O Develop muscle

O Rehabilitate an injury O Improve Balance

O Improve flexibility O Nutritional Education

O Train for a Specific Sport/Event O Motivation

O Other:_____

Please list any specific goals you would like to address.

_____

_____

_____