Health History Form

Date:_____

Last Name:_____ First Name:_____

Mailing Address:_____

Phone #:(Day/Evening/Cell)_____

email:_____

Personal Physician:_____ Phone #:_____

Person to contact in case of emergency:_____Phone #:_____

Gender: __Female __ Male Date of Birth: _____/_____/_____

Number of Children: _____ Your Occupation:_____

Your Blood Pressure:_____/_____ Cholesterol #:_____

Date of last physical exam:_____

Family Medical History - Please check all items that apply to blood relatives (natural children, brothers, sisters, parents and grandparents):

___Heart Disease ___High Blood Pressure ___Diabetes ___Stroke __Osteoporosis
___Cancer ___Other:_____

Have any of your blood relatives died from heart attack before age 60? ___Yes ___No

Check all reasons you have been hospitalized: ___Check-up ___Injury ___Operation
___Illness ___Pregnancy ___Other:_____

Check any operations you have had: ___Back ___Heart ___Hernia ___Joint
___Lung ___Neck ___Ears ___Eyes ___Other:_____

Check all of the following for which you have been diagnosed or treated by a physician or health-care professional: ___Asthma ___Ulcer ___Epilepsy ___Heart problem ___Stroke ___Back strain ___Diabetes ___Gout ___Neck strain ___Thyroid ___Cancer ___Emphysema ___High blood pressure ___Hyperlipidemia ___Rheumatoid arthritis ___Other:_____

List all medications you are presently taking, or have taken in the last six months:

_____

_____

List all fractures (broken bones) you have had:_____

_____

Check the space indicating how often you have each of the following:

	Often	Sometimes	Never
Fatigue	_____	_____	_____
Abdominal pain	_____	_____	_____
Chest pain	_____	_____	_____
Low back pain	_____	_____	_____
Arm or shoulder pain	_____	_____	_____
Neck pain	_____	_____	_____
Leg pain	_____	_____	_____
Knee discomfort	_____	_____	_____
Ankle or foot discomfort	_____	_____	_____
Swollen or painful joints	_____	_____	_____
Feeling faint	_____	_____	_____
Dizziness	_____	_____	_____

Do you smoke? ___Yes ___No

If you are a former smoker, how many years since you stopped smoking?

___1 ___2 ___3+

How many hours per week do you work? _____

How many hours per night do you sleep? _____

What do you consider a healthy weight for yourself? _____lbs.

Are you on a calorie-restricted diet? ___Yes ___No

How do you rate the level of stress in your life? ___High ___Medium ___Low

How were you referred to this studio? _____

_____

NOTES: