HEALTH HISTORY QUESTIONAIRE

All information is kept strictly confidential.

NAME:				TODAYS DATE:
ADDRESS:	CITY:	STATE:	ZIP CODE:	
PRIMARY PHONE: HOME WORK OTHER	ALT. PHONE:	EMAIL ADDRESS:		

DATE OF BIRTH:	AGE:	SEX:	HEIGHT:	WEIGHT:	WEIGHT ONE YEAR AGO:	WEIGHT AT AGE 21:

RELATIONSHIP STATUS:

SINGLE MARRIED SEPARATED DIVORCED WIDOWED OTHER: _____

EMERGENCY CONTACT:	RELATION:	PHONE:

EMPLOYER:	OCCUPATION:
PRIMARY PHYSICIAN:	
DATE OF LAST PHYSICAL EXAM:	HEALTH INSURANCE:

REFERRED BY:

Please list the medications you are currently taking (include dosage and purpose):

Please list the dietary supplements you are currently taking:

What are your goals?

What are your primary complaints/concerns?

What do you expect from working with a Personal Coach?

Number of hours, on average you work per week: _____

Do you spend more than 25% of time on the job doing the following? (circle all that apply) yes no

Sitting at a Desk Standing Walking Driving Using a computer Lifting or carrying loads

How would you rate you work place stress? (0= None, 10= Maxed out): _____

How would you rate the amount of stress you have in your life? (0= None, 10= Maxed out): _____

Do you have diabetes? yes no

Does anyone in your family have diabetes? yes no

If yes, please indicate who:

Have you had a stroke? yes no

Circle any who have had a heart attack or suffered another cardiovascular disease. Please indicate ages if known.

Father: age _____ Mother: age____ Brother: age _____ Sister: age _____ Grandparent: age_____

Do you have Asthma? yes no

Are you, or do you have any reason to believe you may be pregnant? yes no

Have you ever been diagnosed with or treated by a physician or health professional for any reason? yes no

If yes, please explain:

Do you often have pains in your heart, chest or surrounding areas, especially during exercise? yes no

Have you experienced shortness of breath? yes no

yes no

Do you ever experience dizziness or felt faint? yes no

Do you experience swelling in or around your ankles? yes no

Do you ever experience unusual fatigue? yes no

Do you smoke cigarettes daily, or have you quit smoking within the past two years? yes no

If yes, how many cigarettes do you or did you smoke?: _____ packs per day

How much alcohol do you consume and how often? _____

(Optional) Are you currently using prescription or recreational drugs for any other purpose than medically recommended? yes no

Has you doctor ever told you that you have high blood pressure? yes no

What was your blood pressure at your last doctor's visit? _____

Do you have any food allergies (food, medication, or other)?

If yes, please list below:

Do you experience digestive issues?

If yes, please explain:

What are your daily eating habits like? (circle all that apply)

Skip breakfast *Skip lunch* *Skip dinner* *Eat late* *Eat out* *Eat take out*

Coffee_____ cups per day *Soda_____cans/bottles per day* *Water____glasses per day*

Eat: *Organic* *Processed Foods* *Home cooked meals* *Frozen dinners* *Pre-made meals*

What are your current activity patterns?

Cardiovascular exercise: sessions per week_____ intensity_____ duration_____

History: <3 months 3-12 months >12 months

Strength training: sessions per week_____ intensity_____ duration_____

History: <3 months 3-12 months >12 months

Flexibility training: sessions per week_____ intensity_____ duration_____

History: <3 months 3-12 months >12 months

Have you experienced menopause?

If yes, at what age?_____Do you take hormone replacement medication? *yes* *no*

Do you have trouble falling asleep at night? *yes* *no*

If you awake at night do you have difficulty falling back asleep? *yes* *no*

Do you have trouble waking in the morning? *yes* *no*

What time do you go to bed at night?_____ Are your sleeping habits routine? *yes* *no*

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

How many hours do you think you need?_____

Please list all surgeries and dates:

Have you had any injuries or orthopedic problems in the past? *yes* *no*

If yes, please list below:

Are there any areas of the body in which you have pain?: (Back, neck, shoulder, knee) *yes* *no*

Please list below and list the level of pain next to each one. 1= very slight, 5=most painful