Health Studio
Recovery & Performance Therapy

Health History Questionaire

Date: Team Member:

Contact Information (phone/e-mail):

Street Address

City State Zip Code

Gender: M / F D.O.B.: Weight: Height:

Known Risks & Symptoms

Heart Disease	yes	no	Osteoporosis	yes	no
Pulmonary Disease	yes	no	Arthritis or Joint Pain	yes	no
Metabolic Disease	yes	no	Back Pain or Spine Disorder	yes	no
Fam. History CHD	yes	no	Musculoskeletal Pain or Injury	yes	no
High Blood Pressure	yes	no	Hernia	yes	no
High Cholesterol	yes	no	Surgery	yes	no
Smoking	yes	no	Hypoglycemia	yes	no
Sedentary	yes	no	GI Disorder	yes	no
Shortness of Breath	yes	no	High Triglycerides	yes	no
Irregular or Accelerated HR	yes	no	Anemia	yes	no
Pre/post natal (3 months post)	yes	no	Other	yes	no

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a physician?	yes	no
Do you feel pain in your chest when you do physical activity?	yes	no
In the past month, have you had chest pain when you were not doing physical activity?	yes	no
Do you ever loose your balance because of dizziness or do you ever loose consciousness?	yes	no
Do you have a bone or joint problem that could be made worse by a change in your physical activity?	yes	no
Is your doctor currently prescribing medication for your? EX. blood pressure or Diabeties	yes	no
Do you know of any other reason why you should not do physical activity?	yes	no

Risk Level: Low Medium High

Health & Healing Advised? yes no

Client Name (last, first):

Name of Emergency Contact:

Primary phone: Secondary Phone:

Client Signature: **Date:**