Updated _____

MEDICAL HISTORY FORM

Name: _____

Age: _____ DOB: _____ Sex: ○ M ○ F

Emergency Contact:
Name: _____
Phone #: _____

Medical history/alert info(check all that apply):

○ Allergies _____
○ Arthritis _____
○ Cancer _____
○ Diabetes _____
○ Dizziness
○ Epilepsy or other neurological problems
○ High or ○ low blood pressure
○ High cholesterol
○ Heart problems _____
○ Immune system problems _____
○ Infectious diseases _____
○ Kidney problems
○ Lung problems _____
○ Obesity
○ Osteopenia/Osteoporosis
○ Pregnant or might be pregnant
○ Sexually transmitted disease _____
○ Smoke (amt) _____ or quit (year) _____
○ Stomach problems _____
○ Stroke
○ Thyroid problems _____
Other: _____
_____
_____
Surgeries: _____
_____
_____
Medications: _____
_____
_____

Past Injuries: _____
_____

_____

Employment: ○ Working Full Time ○ Part Time
○ Outside Home ○ From Home ○ Homemaker
○ Student ○ Retired

Occupation: _____
I (mark one): ○ exercise ○ do not exercise
Type of Exercise: _____
_____
_____
Frequency: _____
Number of years: _____
Do you have any pain with exercise? ○ Yes ○ No
Where and description?
_____
_____
_____
_____
_____

Describe yourself:
I:
○ Love to exercise
○ Like to exercise
○ Exercise to exercise
○ Know I need to exercise
○ Exercise because the doctor told me to
○ Hate to exercise
Have you received physical therapy or chiropractic treatments: ○ YES ○ NO
If yes, where: _____
Do you drink alcohol? Type and amount/week
_____
_____

What are your goals? _____
_____
_____
_____
What are your favorite things to do (hobbies):
_____
_____