Health History Questionnaire

Personal Information

Name: _____ Date: _____

Address: _____

_____

Primary Phone: _____ Email: _____

Date of Birth: _____ Occupation: _____

Gender: _____ Height: _____ Weight: _____

Please Circle One: Student Faculty/Staff Administration Alumni

Emergency Contact Information

Name: _____ Date: _____

Address: _____

_____

Home Phone: _____ Email: _____

Cell Phone: _____

Medical History

Please list any medications you may be taking and your reason for taking them
(*Prescribed or over-the-counter*)

1._____

2._____

3._____

4._____

Please read the following questions and answer them honestly to the best of your ability.

1. Have you experienced high blood pressure within the last 5 years ?	☐ Yes	☐ No	☐ Don't Know
2. Have you had high cholesterol within the last 5 years ?	☐ Yes	☐ No	☐ Don't Know
3. Have you had a stroke or heart attack within the last 10 years?	☐ Yes	☐ No	☐ Don't Know
4. Do you ever get dizzy, unbalanced, or lose consciousness?	☐ Yes	☐ No	☐ Don't Know
5. Do you have any chronic illness or condition?	☐ Yes	☐ No	☐ Don't Know
6. Have you had a surgery within the last 5 years?	☐ Yes	☐ No	☐ Don't Know
7. Have you smoked within the last 5 years?	☐ Yes	☐ No	☐ Don't Know
8. Do you have diabetes?	☐ Yes	☐ No	☐ Don't Know
9. Do you have any breathing conditions (asthma, COPD, etc)?	☐ Yes	☐ No	☐ Don't Know
10. Does anyone in your family have a history of any of the above symptoms?	☐ Yes	☐ No	☐ Don't Know

If you answered YES to any of the questions above please elaborate on your answer below

_____

_____

_____

_____

_____

_____

_____

Please mark an (X) next to any of the following symptoms that you current experience or have experienced in the last 6 months

_____Headaches/Migraines	_____Neck Pain/Stiffness	_____Shoulder Pain (L – R)
_____Shortness of Breath	_____Wrist/Hand Pain (L- R)	_____Elbow Pain (L – R)
_____Kyphosis (rounded back)	_____Lordosis(sway back)	_____Scoliosis
_____Upper Back Pain	_____Mid Back Pain	_____Low Back Pain
_____Hip Pain (L – R)	_____Knee Pain (L – R)	_____Ankle/Foot Pain (L – R)
_____Depression	_____Chronic Fatigue	_____Irritability
_____Menstrual Pain	_____Constipation	_____Swelling

Are you currently pregnant? _____
If so, how many weeks along are you? _____

Lifestyle & Exercise

1. How many times a week do you currently exercise?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐>6

2. How many days per week do you engage in aerobic exercise?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

3. How many days per week do you engage in resistance training (working out with weights)?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

4. How many days per week do you engage in flexibility training?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7

5. How active do you consider yourself?

☐Not active ☐Somewhat Active ☐Moderately Active ☐Active ☐Very Active

6. How stressful would you consider your occupation on a scale of 1-10 (1=no stress, 10=very stressful)?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

7. Do you prefer exercising individually or in a group setting?

Individual ☐ Group ☐ Both ☐

8. If you do not exercise currently, please list some of your current barriers to engaging in exercise:

_____

_____

_____

_____

_____

9. If you exercise 1 or more times per week, please list the current exercise activities that you currently engage in:

_____

_____

_____

Goal Setting

When setting goals they should follow the acronym SMART: Specific, Measurable, Attainable, Realistic and Timely. When setting goals, please keep these ideas in mind.

Please rank your goals independently using the following 1-10 scale:

Not Important		Somewhat Important			Important			Very Important	
1	2	3	4	5	6	7	8	9	10

- Improve cardiovascular fitness _____
- Reduce body fat level _____
- Increase muscular tone _____
- Increase muscular strength _____
- Improve flexibility _____
- Lose weight _____
- Gain weight _____
- Increase energy level _____
- Enjoyment _____
- Improve performance for a specific sport/activity _____
    - If important please list sport/activity _____
- Other: _____

Please list any short term goals that you wish to complete (within the next 3-6 months):

_____

_____

_____

_____

_____

Please list any long term goals that you wish to complete (within the next 6-18 months)

_____

_____

_____

_____

_____