Name_____

PEACHTREE FITNESS

HEALTH HISTORY QUESTIONNAIRE (Your answers are confidential.)

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Cell Phone:	
Work Phone:	Email:	Occupation:
In case of Emergency, please contact:	Phone: Relationship:	

MEDICAL INFORMATION

Physician:	Phone:

Are you under the care of a physician, chiropractor, or other health care professional for any reason?
If yes, please list reason:

Are you taking any medication?
(If yes, please complete the following.)

Type: Dosage/Frequency Reason for Taking:

_____
_____
_____
_____
_____

Please list any allergies:

Has your doctor ever told you that your blood pressure was too high?	___Yes	____No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	___Yes	____No
Are you over the age of 65?	___Yes	____No
Are you accustomed to vigorous exercise?	___Yes	____No
Is there any reason not mentioned why you should not follow a regular exercise program. If you, please explain:	___Yes	____No
Have you recently experienced any chest pain associated with either exercise or stress? If yes, please explain:	___Yes	___No

Name_____

SMOKING

Please put a check mark below that describes your current habits:

____Non-user or former user; Date quit:_____
____Cigar and/or pipe
____15 or less cigarettes per day
____16-25 cigarettes per day
____26-35 cigarettes per day
____More than 35 cigarettes per day

FAMILY AND PERSONAL MEDICAL HISTORY

If there is family history for any condition, please put a check mark below to the **left**. If you are personally experiencing any of these conditions, fill in the information on the line to the **right**.

____Asthma:_____

____Respiratory/Pulmonary Conditions:_____

____Diabetes: Type I:_____ Type II:_____ How long?_____

____Epilepsy: Petite Mal:_____ Grand Mal:_____ Other:_____

____Osteoporosis:_____

LIFESTYLE AND DIETARY FACTORS

Please fill in the information below:

___Occupational Stress Level: ____Low ____Medium ____High
___Energy Level ____Low ____Medium ____High
___Caffeine Intake/Daily:_____ Alcohol Intake/Daily:_____
___Colds per year:_____ Anemia:_____
___Gastrointestinal Disorder:_____
___Hypoglycemia:_____
___Thyroid Disorder:_____
___Pre/Postnatal:_____

CARDIOVASCULAR

Please fill in the information below:

___High Blood Pressure:_____ Hypertension:_____
___High Cholesterol:_____
___Hyperlipidemia:_____
___Heart Disease:_____
___Heart Attack:_____ Stroke:_____
___Angina:_____ Gout:_____

MUSCULOSKELETAL INFORMATION

Please describe any past or current musculoskeletal conditions you have had such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

___Head/Neck:_____
___Upper Back:_____
___Shoulder/Clavicle:_____
___Arm/Elbow:_____
___Wrist/Hand:_____
___Lower Back:_____
___Hip/Pelvis:_____
___Knee/Thigh:_____

Name_____

___Arthritis:_____
___Hernia:_____
___Surgeries:_____
___Other:_____

NUTRITIONAL INFORMATION

Are you on any specific food/diet plan at this time? ___Yes ___No
If yes, please list:

Do you take dietary supplements? ___Yes ___No
If yes, please list:

Do you experience frequent weight fluctuations? ___Yes ___No

Have you experienced a recent weight gain or loss? ___Yes ___No
If yes, list change:

How long?

How many beverages do you consume per day that contain caffeine?

How would you describe your nutritional habits?

Other food/nutritional issues you want to include *(food allergies, mealtimes, etc.)*

WORK AND EXERCISE HABITS

Please put a check mark that best describes your work and exercise habits:
___Intense occupational and recreational exertion
___Moderate occupational and recreational exertion
___Sedentary occupational and intense recreational exertion
___Sedentary occupational and moderate recreational exertion
___Sedentary occupational and light recreational exertion
___Complete lack of all exertion

To what degree do you perceive your environment as stressful?
Work: ___Minimal ___Moderate ___Average ___Extremely
Home: ___Minimal ___Moderate ___Average ___Extremely

Do you work more than 40 hours per week?
___Yes No___

Please make any other comments you feel are pertinent to your exercise program.
_____
_____

Name_____ Signature_____
Date_____ Signature of parent (if under 18 years of age)_____
Witness_____