Client Health & Information Form

Please fill out the following questionnaire to help me get to know you and serve you best during our time together. Thank you!

PERSONAL INFORMATION

NAME:____BIRTHDATE:___/___/___AGE:_______

OCCUPATION:______________________________________PHONE:__________________________

ADDRESS:____

EMAIL ADDRESS:____

EMERGENCY CONTACT:_____________________________PHONE:__________________________

PLACE OF BIRTH:_____________________ HEIGHT:__________ CURRENT WEIGHT:___________

WOULD YOU LIKE YOUR WEIGHT TO BE DIFFERENT?_______________ HOW SO?___________

WEIGHT SIX MONTHS AGO:__________ WEIGHT ONE YEAR AGO:__________

CHILDREN:_____________________________ PETS:_______________________________________

RELATIONSHIP STATUS:___________________ HOURS OF WORK PER WEEK: _________________

PHYSICAL ACTIVITY & HEALTH INFORMATION

1. Have you ever been told by a physician that you should only participate in medically supervised activity? Y/N
   If yes, why?____
2. Do you have chest pain brought on by physical activity? Y/N
3. Do you tend to lose consciousness or fall over as a result of dizziness? Y/N
4. Has a doctor recommended medication for blood pressure and/or a heart condition? Y/N
   If yes, explain:____
5. Do you have a bone or joint problem that could be aggravated by physical activity? Y/N
   Please explain:____
6. Have any metal parts been implanted in your body? Ex. Plates, screws, etc. Y/N
   Please explain:____
7. Do you have, or have you previously had, any of the following conditions?
   a. Heart Condition Y/N/Meds______________________________________
   b. Diabetes Y/N/Meds______________________________________
   c. Asthma Y/N/Meds______________________________________
   d. Angina Y/N/Meds______________________________________

e. High Blood Pressure Y/N/Meds____________________________________
f. Migraines Y/N/Meds____________________________________
g. Depression/Anxiety Y/N/Meds____________________________________
h. Bursitis Y/N/Meds_________________Where?_____________
i. Arthritis Y/N/Meds_________________Where?_____________
j. Hernia Y/N/Meds_________________Where?_____________
k. Cancer Y/N/Meds_________________Where?_____________
l. Back Pain Y/N/Meds_________________Where?_____________
m. Recent Surgery Y/N/Meds_________________Where?_____________
n. Pregnancy Y/N/Due Date_________________________________
o. Eating Disorder or Body Dysmorphia Y/N/Treatment________________________________

Please explain any other details regarding your medical history that you feel would be important for me to know. Any serious illnesses, hospitalizations or injuries?

____

____

Please list all medications and supplements: ____

____

Please list your main health concerns: ____

____

____

Other concerns and/or goals? ____

____

____

At what point in your life did you feel the best? Why?____

____

____

What do you most hope to get out of our time together? ____

____

____

Is there something specific that you would like to accomplish?___________________________________

____

I have the following exercise equipment at home:____

____

Current Exercise Regimen / Frequency?____

____

Do you play any sports or have a history of playing sports? _____________________________________

____

What is your favorite hobby or interest? What do you do for fun?________________________________

____

The most important thing I could do to improve my health is: __________________________________

____

How is your sleep? __________ **How many hours?** __________ **Do you wake up at night?**_____________

Do you suffer from pain, stiffness or swelling? Where?____

Constipation / Diarrhea / Gas / Other digestive issues? ______________________________________

Allergies or sensitivities? Explain: ____

Are your periods regular? __________ **Typical length of flow:** __________ **Menopause?** _____________

Painful or symptomatic? Explain: ____

Birth control history: ____

History of yeast infections or Urinary Tract Infections?____

FOOD INFORMATION

What were your favorite foods as a child? Breakfast, lunch, dinner, snacks? ________________________

____

What is your food like currently? What do you typically eat for breakfast, lunch or dinner? ____________

____

Will family and/or friends be supportive of your desire to make food/lifestyle changes? ______________

____

Do you cook? ___________________ **What percentage of your food is home cooked?**__________________

Where does the rest of your food come from? ____

Do you crave sugar, coffee, cigarettes, or have any major addictions? ______________________________

Anything else you would like to share? ____

____

____

I certify that the above statements are true and correct.

Signature:____Date:________________