

Confidential Health History

Please Write or Print Clearly

Name: _____

Address: _____

Email Address: _____ How often do check email? _____

Telephone Numbers Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current Weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Occupation: _____ Hours of work per week: _____

Do you sleep well? _____ Do you wake up at night? _____ What times? _____

To urinate? _____ What time do you generally get up in the morning? _____

Constipation/ Diarrhea? _____ Explain: _____

What blood type are you? _____ What is your ancestry? _____

Women: Are your periods regular? _____ How many days is the flow? _____ How frequent? _____

Painful or symptomatic? _____ Please explain: _____

Do you take any supplements or medications? If so, which _____

Are there any healers, helpers, or therapies with which you are involved? _____

What role does exercise play in your life? _____

Do you drink coffee, alcohol, smoke, or have any addictions? _____

What percentage of your food is home cooked? _____ Where do you get the rest of it? _____

Serious illness/ hospitalizations/ injuries? _____

What is your chief concern? _____

Other concerns? _____

Physical Activity Readiness Questionnaire (PARQ)

Please read each question carefully and circle either YES or NO.

1. Has a doctor ever said that you have a heart condition and recommended only medically supervised physical activity? Yes/ No
2. Do you have chest pain brought on by physical activity? Yes/ No
3. Do you tend to lose consciousness or fall over as a result of dizziness? Yes/ No
4. Has a doctor ever recommended medication for your blood pressure or heart condition? Yes/ No
5. Do you have a bone or joint problem that could be aggravated by purposed physical activity? Yes/ No
6. Are you aware, through your own experience or a doctor's advice, of any physical reason to have medical supervision while exercising? Yes/ No
7. Are you over the age of 65 and not accustomed to vigorous exercise? Yes/ No

If you answered YES to one or more of the questions above, please answer and initial the following question: 8.

Have you ever consulted your physician about increasing your physical activity and/ or performing a fitness assessment? Yes/ No Initial: _____

Please check the conditions that apply to you and your parents:

- | | | | |
|--|--------------------------|--|-----------------------------------|
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Heart disease or stroke | <input type="checkbox"/> You <input type="checkbox"/> Parent | Food Allergies |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | High blood pressure | <input type="checkbox"/> You <input type="checkbox"/> Parent | Neuromuscular disease |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | High triglycerides | <input type="checkbox"/> You <input type="checkbox"/> Parent | Arteriosclerosis |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Cancer | <input type="checkbox"/> You <input type="checkbox"/> Parent | Gall bladder disease |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Lung/ pulmonary disease | <input type="checkbox"/> You <input type="checkbox"/> Parent | Constipation |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Kidney disorder | <input type="checkbox"/> You <input type="checkbox"/> Parent | Psychological problems |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Osteoporosis | <input type="checkbox"/> You <input type="checkbox"/> Parent | Anorexia |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Ulcer | <input type="checkbox"/> You <input type="checkbox"/> Parent | Bulimia |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Gastrointestinal disease | <input type="checkbox"/> You <input type="checkbox"/> Parent | Compulsive overeating |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Diarrhea | <input type="checkbox"/> You <input type="checkbox"/> Parent | Other medical problems |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Depression | <input type="checkbox"/> You <input type="checkbox"/> Parent | Currently pregnant/ breastfeeding |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Diabetes mellitus | <input type="checkbox"/> You <input type="checkbox"/> Parent | Monitored by physician |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Weight issues | <input type="checkbox"/> You <input type="checkbox"/> Parent | Recommended high level care |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Arthritis | <input type="checkbox"/> You <input type="checkbox"/> Parent | Special diet |
| <input type="checkbox"/> You <input type="checkbox"/> Parent | Anemia | | |

List any medications you are currently taking for the above conditions, if applicable: _____
