

## 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: \_\_\_\_\_

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