HEALTH HISTORY QUESTIONNAIRE

NAME	DATE		
Please read each item carefully and indicate whether you have experienced any of the following conditions. Your accurate answers will help us design a safer and more effective program for you. Write on the back if needed.			
Symptom , Condition or Surgery	**Yes**	**No**	**If yes, please explain**
Back pain (specify type & location)			
Hip pain (specify type & location)			
Neck pain (specify type & location)			
Shoulder pain (specify type & location)			
Knee pain (specify type & location)			
Ankle pain (specify type & location)			
Foot pain (specify type)			
Respiratory problems			
Heart conditions			
Chest pains			
Dizziness or shortness of breath			
High blood pressure			
Bone or joint problems (arthritis, osteoporosis, etc)			
Any surgery & when			
Muscular tension in shoulders or upper back			
Headaches			
Increased anxiety or stress			
Fatigue/ Disruptive sleep or insomnia			
Do you play any sports or exercise? What?			
Do you have any medical condition that may be affected by exercise?			
Do you know of any other factor which may affect your ability to engage in an exercise program?			
Are you being treated by a Physical Therapist, Chiropractor at this time?			

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