MEDICAL HISTORY FORM

Updated _____

Name _____

Age _____ DOB _____ Sex: ____ M ____ F

Emergency contact:

Name _____

Phone # _____

Medical history/alert info (mark all that apply):

____ Allergies _____

____ Arthritis _____

____ Cancer _____

____ Diabetes _____

____ Dizziness

____ Epilepsy or other neurological problems

____ High or ____ low blood pressure

____ High cholesterol

____ Heart problems _____

____ Immune system problems _____

____ Infectious diseases _____

____ Kidney problems

____ Lung problems _____

____ Obesity

____ Osteopenia/Osteoporosis

____ Pregnant or might be pregnant

____ Sexually transmitted disease _____

____ Smoke (amt) _____ or quit (year) _____

____ Stomach problems _____

____ Stroke

____ Thyroid problems _____

Other _____

_____

Surgeries _____

_____

_____

Medications _____

_____

_____

Past injuries _____

_____

_____

Employment:

____ Work Full-Time ____ Part Time

____ Outside Home ____ From Home

____ Homemaker ____ Student ____ Retired

Occupation _____

I (mark one): ____ exercise ____ do not exercise

Type of exercise _____

_____

_____

Frequency _____

Number of years _____

Any pain with exercise? ____ Yes ____ No

Where? _____

_____

Describe yourself:

____ I love to exercise

____ I like to exercise

____ I exercise to exercise

____ I know I need to exercise

____ I exercise because my doctor told me to

____ I hate to exercise

Have you received physical therapy or chiropractic treatments? ____ Yes ____ No

If yes, where _____

Do you drink alcohol? (Type and amount/week)

_____

_____

What are your goals? _____

_____

_____

What are your favorite things to do (hobbies)?

_____

_____