
# Client Health History

## Client Information

☐Miss ☐Mr. ☐Mrs. ☐Ms.

Last Name | First Name | Middle Initial

Address

City | Province | Postal Code

( ) | ( )

Home Phone | Business Phone

Date of Birth (MM/DD/YY)

**Existing Medical Conditions** – Please check the appropriate conditions

☐Diabetes
☐Asthma
☐Heart Condition
☐Epilepsy
☐Hernia
☐Ulcer
☐Hearing Loss
☐Pregnancy
☐Arthritis
☐Obesity
☐Cholesterol
☐Anemia
☐Eye Problems
☐Thyroid Problems

**Family Health History**

1. Circle any family member who is deceased due to a heart attack before the age 50:

Father Mother Brother Sister Grandparent

2. List any major illnesses your immediate family suffers from:

.....

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**Medications**
Are you currently taking any medications? ☐YES ☐NO
If you checked YES, please list the medication and for what condition

Medication ..... Condition .....

Medication ..... Condition .....

Medication ..... Condition .....

**Injuries**
Do you have pain or have you injured any of the following areas:

☐ Neck ☐ Upper Back ☐ Lower Back
☐ Shoulder R / L ☐ Elbow R / L ☐ Wrist R / L
☐ Hip R / L ☐ Knee R / L ☐ Ankle R / L

**Health Care Professionals**
Do you have a regular treatment from any of the following individuals:

☐ General Practitioner (annual) ☐ Chiropractor
☐ Massage Therapist ☐ Physiotherapist
☐ Acupuncturist ☐ Naturopath

**Current Activity Levels**

1. Do you consider yourself to be active? ☐ YES ☐ NO

2. How often do you exercise? 0 1 2 3 4 5 6 7 days a week

3. What exercise do you enjoy?

☐ Walking ☐ jogging ☐ running
☐ Swimming ☐ tennis ☐ squash
☐ Group exercise ☐ Stairmaster ☐ weight training
☐ Cycling ☐ indoor cycling

Other .....

4. Any reason why you can't exercise regularly? .....

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**Lifestyle(circle one only)**

1. Rate your stress on a daily basis: Low Moderate High

2. How much sleep do you average each night? 5 6 7 8 9 10 hours

3. Do you smoke? YES NO

4. Alcohol consumption? None Mild Moderate Frequent

**Nutritional Habits**

1. Present Weight ..... lbs. Ideal Weight ..... lbs.

2. Do you follow a special diet? YES NO

3. How would you rate your eating habits? Poor OK Good Very Good

4. Is weight loss one of your primary exercise goals? YES NO

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