

SPINE & SPORT

THErapy • PERFORMANCE • WELLNESS

HEALTH HISTORY

NAME: _____ DATE: _____ / _____ / _____

PLEASE CIRCLE "Y" FOR YES OR "N" FOR NO AND FILL-IN THE BLANKS AS NECESSARY. THANK YOU.

1. (Y / N) DO YOU SMOKE? IF YES, HOW MANY PACKS PER DAY? _____
(Y / N) ARE YOU TRYING TO QUIT? IF YES, WHAT METHOD ARE YOU USING? _____
2. (Y / N) HAS YOUR DOCTOR EVER TOLD YOU THAT YOUR BLOOD PRESSURE WAS TOO HIGH?
(Y / N) HAS YOUR DOCTOR EVER TOLD YOU THAT YOUR BLOOD PRESSURE WAS TOO LOW?
3. (Y / N) HAVE YOU, OR A CLOSE FAMILY MEMBER, EVER BEEN DIAGNOSED WITH DIABETES?
4. (Y / N) DO YOU HAVE ANY KNOWN CARDIOVASCULAR PROBLEMS (ABNORMAL ECG, PREVIOUS HEART ATTACK, ATHEROSCLEROSIS, ETC.)? IF YES, PLEASE INDICATE. _____
5. (Y / N) HAS YOUR DOCTOR EVER TOLD YOU YOUR CHOLESTEROL LEVEL WAS HIGH?
IF YES, PLEASE INDICATE THE TOTAL NUMBER AND RATIO. _____
6. (Y / N) ARE YOU CURRENTLY OVERWEIGHT? IF YES, PLEASE INDICATE HOW MUCH. _____
7. (Y / N) DO YOU HAVE ANY PAST OR CURRENT INJURIES OR ORTHOPEDIC PROBLEMS (BURSITIS, KNEE INJURY, SPINE PROBLEMS, ETC.)? IF YES, PLEASE INDICATE. _____

8. (Y / N) ARE YOU PREGNANT OR POST-PARTUM LESS THAN SIX WEEKS?
9. (Y / N) HAVE YOU HAD A RECENT PHYSICAL EXAM? PLEASE INDICATE THE DATE: ____ / ____ / ____
10. (Y / N) HAS YOUR DOCTOR EVER TOLD YOU THAT YOU HAVE A HEART CONDITION AND SHOULD ONLY PERFORM PHYSICAL ACTIVITY RECOMMENDED BY A PHYSICIAN?
11. (Y / N) HAVE YOU EVER HAD CHEST PAIN WHILE NOT ENGAGING IN PHYSICAL ACTIVITY?
12. (Y / N) DO YOU LOSE YOUR BALANCE DUE TO DIZZINESS OR DO YOU EVER LOSE CONSCIOUSNESS?
13. (Y / N) DO YOU HAVE A BONE OR JOINT PROBLEM THAT COULD BE MADE WORSE BY A CHANGE IN YOUR PHYSICAL ACTIVITY?
14. (Y / N) IS YOUR DOCTOR CURRENTLY PRESCRIBING DRUGS (EX. WATER PILLS) FOR YOUR BLOOD PRESSURE OR HEART CONDITION? IF YES, PLEASE INDICATE. _____
15. (Y / N) DO YOU KNOW OF ANY OTHER REASON WHY YOU SHOULD NOT ENGAGE IN PHYSICAL ACTIVITY? IF YES, PLEASE INDICATE. _____

16. PLEASE REVIEW THE LIST OF CONDITIONS BELOW AND CHECK ALL THAT APPLY TO YOU.

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| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> CANCER | <input type="checkbox"/> BLADDER DIFFICULTIES |
| <input type="checkbox"/> HEART PALPITATIONS | <input type="checkbox"/> SEIZURES OR EPILEPSY | <input type="checkbox"/> INFECTIONS |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> DIFFICULTY WALKING | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> DIZZINESS OR BLACKOUTS | <input type="checkbox"/> JOINT PAIN OR SWELLING | <input type="checkbox"/> AREAS OF SWELLING |
| <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> PAIN AT NIGHT | <input type="checkbox"/> WEIGHT LOSS OR GAIN |
| <input type="checkbox"/> COORDINATION PROBLEM | <input type="checkbox"/> DIFFICULTY SLEEPING | <input type="checkbox"/> UNEXPLAINED PAIN |
| <input type="checkbox"/> WEAKNESS | <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> FEVER, CHILLS OR SWEATS |
| <input type="checkbox"/> FRACTURES | <input type="checkbox"/> NAUSEA OR VOMITING | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> DIFFICULTY SWALLOWING | <input type="checkbox"/> HEARING PROBLEMS |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> BOWEL DIFFICULTIES | <input type="checkbox"/> VISION PROBLEM |

Other _____