SharonFrazier
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HEALTH AND LIFESTYLE QUESTIONNAIRE

Today's Date__________

Name____Birth Date___________Age_______

Home Address____Zip________

Home Phone________________Business Phone_________________E-mail___________________

Employer____Occupation____________________

Business Address____

Emergency Contact____________________________________Relationship____________________

Address____Phone________________________

Physician____

Address____Phone________________________

Date of last physical___________Current Medications_______________________________________

May I have permission to contact your physician regarding your health status?____________________

Family Medical History: List any of your parents or siblings who had the following diseases and their age at the time of occurrence.

	Relative	Age
Cancer	_____________	______
Cardiovascular disease, including		
Heart attack	_____________	______
High blood pressure	_____________	______
High cholesterol	_____________	______
Stroke	_____________	______
Diabetes	_____________	______
Obesity	_____________	______
Osteoporosis	_____________	______

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Personal Medical History: Check the conditions you currently have. If a condition occurred in the past, please check it and indicate how long ago.

_____Allergies
_____Gout
_____Anemia
_____Anorexia/bulimia
_____Arthritis
_____Bone fracture
_____Cancer
_____Chest pain/pressure
_____Lung/Breathing
_____Headaches
_____Heart attack
_____Heart murmur
_____High blood pressure
_____High blood glucose
_____High cholesterol
_____Asthma
_____Bronchitis
_____Emphysema
_____Pneumonia
_____Menstrual problems
_____Neurological problem
_____Depression
_____Diabetes
_____Dizziness
_____Epilepsy
_____High triglycerides
_____Hypoglycemia
_____Kidney problem
_____Leg cramps
_____Liver disease
_____Numbness/tingling
_____Obesity
_____Osteoporosis
_____Stroke
_____Thyroid problems

Other____

Any recent illness, hospitalization or surgery?

____

Orthopedic History: Describe any bone, joint or muscle injuries that you presently have or have had in the past (i.e
neck, shoulder, elbow, low back, hip, knee problems).

Do you presently have pain in any part of your body?

____

____

____

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Physical Activity History:

Do you engage in physical activity on a consistent basis? _______Yes _______No
How long have you exercised? ____
Describe your routine ____
If not currently exercising, have you in the past? _______Yes _______No
When? ____
Describe your past routine ____
What sports and recreational activities do you enjoy? ______________________________

Personal Fitness Goals:

_____Health maintenance _____Increased stamina _____Cardiovascular fitness Other:
_____Weight loss _____Strength and stability _____Muscle toning ____________
_____Flexibility _____Posture _____Balance ____________
_____Pre- and Post-natal _____Sports training _____Bone building

Health Related Behaviors:

Circle your degree of satisfaction (1-6). Circle YES if you plan to change and NO if you do not plan to change:

6 = COMPLETELY SATISFIED
5 = Mostly satisfied
4 = Partially satisfied
3 = Partially dissatisfied
2 = Mostly dissatisfied
1 = COMPLETELY DISSATISFIED

Plan to Change:

Overall Health	1	2	3	4	5	6	Yes	No
Overall Fitness	1	2	3	4	5	6	Yes	No
Activity Level	1	2	3	4	5	6	Yes	No
Energy Level	1	2	3	4	5	6	Yes	No
Weight/Body Fat	1	2	3	4	5	6	Yes	No

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Plan to Change:

Eating Habits	1	2	3	4	5	6	Yes	No
Blood Pressure	1	2	3	4	5	6	Yes	No
Managing Stress	1	2	3	4	5	6	Yes	No
Managing Time	1	2	3	4	5	6	Yes	No
Sleep Patterns	1	2	3	4	5	6	Yes	No
Smoking	1	2	3	4	5	6	Yes	No
Alcohol Use	1	2	3	4	5	6	Yes	No
Positive Attitude	1	2	3	4	5	6	Yes	No

Additional comments:____

____

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Signature____Date___________