Client Health History

Name_____Birthdate_____
Address_____
Home phone_____ email address_____
Cellular phone_____
Emergency contact_____ phone_____

Date of last physical exam_____
Are you currently taking any medications? _____
If yes, please list _____
Have you ever had surgery? _____
If yes, list type of surgery and date performed: _____
_____
_____

Are you now or have you ever been pregnant within the last three months? _____
Have you smoked in the past? _____
If you've quit, how log ago? _____

HAVE YOU EVER HAD OR PRESENTLY HAVE ANY OF THE FOLLOWING?
(please mark if yes)

_____heart attack
_____chest discomfort
_____extra, skipped or rapid heart beats
_____heart murmurs, chills or unusual cardiac findings
_____obesity (more than 20 pounds overweight)
_____Diabetes
_____stroke
_____chronic back pain/problems
_____circulatory problems
_____cancer
_____rheumatic fever
_____pulmonary disease
_____nerve damage
_____shortness of breath
_____elevated cholesterol
_____arthritis
_____muscle or joint problems
_____high blood pressure
_____ankle swelling
_____epilepsy
_____lightheadedness/fainting
_____hypoglycemia
_____asthma
_____orthopedic problems (shoulder, hip knee, foot or ankle, etc.)
_____recent weight loss/gain
_____bone fractures

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:
(If you have answered yes, medical clearance may be necessary.)
_____
_____
_____

Physician's name_____phone_____

Do you feel that you are in good health? _____

THE ABOVE FACTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND I DID NOT MISREPRESENT MY HEALTH IN ANY WAY.
SIGNATURE_____**DATE**_____