Get Out of Back Pain

HEALTH HISTORY QUESTIONAIRE

Name_____ Age_____ Sex_____ Today's Date_____

Address_____ Home Phone_____ Cell or Work Phone_____

City_____ State_____ Zip _____ Height_____ Weight_____

Date of Birth _____ Occupation_____ _____ Are you pregnant? Yes No

How did you hear about us?_____

Known Diagnosis if any_____ _____

How and when did this condition start?_____

What else have you done to treat this condition?_____

What success if any have you had with other treatments? Please be specific as to what worked and what did not work

_____

_____

Do you consider yourself: □ underweight □ overweight □ just right Your weight a year ago_____

Do you exercise? Yes No If Yes, type of exercise_____# times/wk or month_____Duration_____

Other type of exercise_____# times/wk or month_____ Duration_____

Do you smoke? Yes No If Yes, what (cigarettes, pipe, pot)_____#/day or week_____

Do you drink alcohol? Yes No If Yes, what (beer, wine, liquor)_____#/day or week_____

Do you drink coffee or tea? Yes No If Yes, what (coffee, decaf, black tea)_____Cups/day_____

Do you drink soft drinks? Yes No If Yes, what (cola, sugar-free)_____#/week_____

Do you drink water? Yes No If Yes, what (tap, filtered)_____ Glasses/day_____

Are you dieting? Yes No If Yes, type of diet_____How long on this diet?_____

What are your eating habits?_____

Do you have any known food allergies? Yes No If Yes, to what_____

List current health problems for which you are being treated_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Are you taking any medications (prescriptions or over-the-counter)? Please specify what and dosage: _____

_____

Are you taking any supplements? Please specity_____

Date of last physical exam: _____Practitioner name _____ Phone Number _____

Please indicate if you have or have had any of the following:

Past	Present		Past	Present		Past	Present		Past	Present	
□	□	Alcoholism	□	□	Allergies	□	□	Arthritis	□	□	Asthma
□	□	Back Condition	□	□	Bursitis	□	□	Carpal Tunnel	□	□	Diabetes
□	□	Drug Addiction	□	□	Eating Disorder	□	□	Environmental Sensitivities	□	□	Epilepsy
□	□	Fatigue	□	□	Fibromyalgia	□	□	Heart Trouble (any)	□	□	Heart Condition
□	□	Hernia	□	□	High Blood Pressure	□	□	Low Blood Pressure	□	□	Joint Pain
□	□	Migraine	□	□	Nervous Tension	□	□	Osteoporosis	□	□	Sciatica
□	□	Shortness of Breath	□	□	Sinus	□	□	Tight Shoulders	□	□	Ulcers
□	□	Varicose Veins									

□ □ Autoimmune Issues, please specificy_____

□ □ Other_____ □ □ Other_____

I certify to the best of my knowledge the above information is correct and complete. I also understand that Dot Spaet assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.

Signature_____Date_____

Signature of Fitness Coach_____Date_____

Dot Spaet
Back Pain Specialist

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