Asheville Pilates / Health Excellence LLC

Health History and Lifestyle Questionnaire

Section 1:

Name: ________________________ Date: _______________ Email: __________________

Birth Date: (mm/dd/yy) _______________ Age:_______ Height: _______ Weight: _______ □ male □ female

Street Address: ______________________________ City: ______________ State: ____ Zip: _______

Home phone: (___)______________ Work phone: (___)______________ Cell/pager: (___)______________

Employer: ____________________ Occupation: ______________ Referred by: _______________

Spouse / Significant Other: ________________________ Phone: ________________________

Emergency Contact Info:___________________________ Phone: _________________________

Children's name(s) ____

Medical Doctor(s): ________________________________ Phone: (___)____________________

Section 11:

Describe your primary reason for coming here. If your primary reason includes symptoms, please detail.

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____

List your goals for consultation or instruction: 1.____

2.___________________________3.____

Section 111:

If your primary concern is due to discomfort, pain or injury, please complete the following section. If not, then skip to Section 1V.

Date pain /injury: _______________ Date symptoms first appeared: _____________

Level of pain on a scale from 1-10, with 1 being least and 10 being excruciating: _______

Circle words that best describe the pain:

Sharp	Tingling	Aching
Dull	Numb	Variable
Burning	Constant	Radiating
Localized	Nagging	No pain, but stiffness

Factors that aggravate your pain (positions/activities): ________________________________

Factors that relieve your pain (positions/activities): __________________________________

Time of day when pain is most apparent: ____

Do you have any functional limitations in your daily routine, work or recreational activities? yes / no

If yes, describe: ____

Have you ever been knocked unconscious? yes / no

Section IV

Year of last: physical exam ____________ X-ray ____________ blood test__ _____________

Is your blood pressure normal / high / low ? (circle one)

Check each applicable condition you have currently or have had in the past:

anemia	diabetes	hemophilia	polio
appendicitis	eating disorder	hepatitis	rheumatic fever
arthritis	ear infections	HIV	spine disorder (incl. disc herniation)
asthma	emphysema	hypertension	stroke
bursitis	epilepsy	hypoglycemia	thyroid disorder
cancer	fibromyalgia	lupus/other autoimmune	
cirrhosis	foot problems	migraine	
chronic fatigue	glaucoma	multiple sclerosis	
colitis	gout	neurological symptoms	
depression	heart disease	osteopenia/osteoporosis	

List any other significant physical injuries (bone fractures, motor vehicle accidents), pregnancies/childbirth (if applicable), hospitalizations, surgeries or other health-related events and mental illness:

Date	Age	Condition	Treatment	Outcome / Results
_________	____	__________________	_________________________	______________________________
_________	____	__________________	_________________________	______________________________
_________	____	__________________	_________________________	______________________________

List all non-prescription medications (pain relievers, laxatives, antacids, natural remedies, herbs, etc.) currently taking:

Name	Frequency	Name	Frequency
___________________	____________________	_______________	______________________
___________________	____________________	_______________	______________________
___________________	____________________	_______________	______________________

Are you currently seeing any other health related practitioner(s)? If so, please describe nature of therapy and list practitioner's name:

____

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Do you participate in any other form of exercise? Yes / No

If Yes, please describe: ____

Usual work activity ________________________ active / sedentary

Describe your energy level: **low** 1 2 3 4 5 **high**

Check if you wear: contact lenses glasses orthotics dentures/bridge pacemaker prosthesis

Women Only

Are you pregnant? yes / no If yes, number of weeks: __________ Due date: __________

Describe any complications: ____

Birth control, if any: ____