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health history form:

name: _____ *date:* _____ *dob:* _____

age: _____ *height:* _____ *weight:* _____

Emergency information: list a relative or friend whom we can contact in case of emergency:

contact name/relationship: _____ *phone:* _____

physician's name: _____ *phone:* _____

do you have or have you had any of the following: (circle all that apply)

<i>anemia</i>	<i>asthma</i>	<i>diabetes</i>	<i>high blood pressure</i>
<i>pulmonary disease</i>	<i>kidney disease</i>	<i>fibromyalgia</i>	<i>heart disease</i>
<i>arthritis</i>	<i>fainting spells</i>	<i>back/leg pain</i>	<i>poor vision</i>
<i>knee pain</i>	<i>poor hearing</i>	<i>shoulder pain</i>	<i>ankle pain</i>
<i>swelling of hands/feet</i>	<i>osteoporosis</i>	<i>cancer: type:</i> _____	
<i>heart attack</i>	<i>cardiac pacemaker</i>	<i>stroke</i>	<i>heart surgery</i>
<i>irregular heart rhythms</i>	<i>other heart problems:</i> _____		

please describe any conditions that are circled:

please list medications you are currently taking:

name of medicine:

reason for use:

have you had any surgeries/injuries/orthopedic problems, any other conditions that would limit ability to exercise? if so, please describe: _____

have you had any injuries that have required physical therapy or chiropractic services? if so, please describe: _____

do you smoke? ___ yes ___ no are you a former smoker? ___ yes ___ no quit date _____

history of smoking behavior:

do you drink alcohol? ___ yes ___ no

history of drinking behavior:

I attest that the information I have given is correct and agree that I am physically able to participate in an exercise program.

signature

date