Health History & Client Intake Form

Personal Information

Full Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Emergency Contact

Name: _____

Phone: _____

Relationship: _____

Physician Information

Physician's Name: _____

Phone: _____

Health History & Current Conditions

Please check any conditions that apply to you:

[ ] Headaches [ ] Allergies [ ] Arthritis/Tendonitis [ ] Cancer

[ ] TMJ [ ] Skin Conditions [ ] Heart/Circulation Issues

[ ] Joint Surgery [ ] High/Low Blood Pressure [ ] Major Accident

[ ] Varicose Veins [ ] Blood Clots [ ] Neck/Back Injuries

[ ] Diabetes [ ] Fibromyalgia [ ] Numbness

[ ] Sprains/Strains [ ] Recent Injuries

Explain any conditions you have checked above:

_____

_____

Health History & Client Intake Form

Are you currently taking any medications? If so, please list them:

_____

Do you have any allergies (food, medication, environmental)?

_____

Do you have any dietary restrictions or specific nutrition concerns?

_____

How would you describe your current level of physical activity?

[ ] Sedentary [ ] Lightly Active [ ] Moderately Active [ ] Very Active

Do you have any current injuries or physical limitations that may affect your ability to exercise?

_____

How would you describe your energy levels on a daily basis?

[ ] High [ ] Moderate [ ] Low

How many hours of sleep do you typically get per night?

[ ] Less than 5 [ ] 5-6 [ ] 7-8 [ ] More than 8

Do you experience frequent stress or anxiety?

[ ] Yes [ ] No

Signature: _____

Date: _____