Name ______________________________ DOB ____________

# Health History

Our goal is to address the multitude of factors that contributes to poor health and provide care that is individualized to you. Please provide the following information:

**Are you:** Right-handed? Left-handed?

**Employment/Task Demands**

How many hours do you spend in computer/desk work per day? ____________

How much and how often do you lift objects heavier than 10 pounds?

# of times/day: ________

Average weight of items lifted: __________

**Where do you live?**

House Apartment

**Accessible by:** Stairs Elevator

**With whom do you live?**

Alone Spouse Partner

Child Other relative

Pets Other

**Do you use an assistive device for mobility?**

Yes No

If yes, please name: ___________________________

**Do you have any uncorrected vision or hearing problems?**

Yes No

**Health Habits**

Please rate your health:

Excellent Good

Fair Poor

Do you exercise beyond your daily activities or participate in any hobbies or sports?

Yes

Please describe the exercise, sport or hobby:

____________________________________

____________________________________

____________________________________

How many days per week do you exercise or perform physical activity? __________

For how many minutes, on an average day? _______

No

Are you satisfied with your level of physical activity?

Yes No

If not exercising, do you intend to become physically active?

Yes, in the next 30 days Yes, in the next 6 months

What would you be interested in learning from a health coach or exercise specialist? ________________________________

____________________________________________________

________________________________________________

No

Do you sleep well? Yes No

How many hours per night? ________

Do you feel tired and fatigued during the day? Yes No

Do you snore? Yes No

Do you stop breathing during sleep? Yes No

How do you feel about your weight?

Satisfied Would like to gain Would like to lose

Are you satisfied with your nutritional health? Yes No

I have found a positive balance between career life, active life, social life and family life. (Circle one)

1 2 3 4 5

Disagree Agree

I have developed helpful strategies for managing my time and life stress as it affects me. (Circle one)

1 2 3 4 5

Disagree Agree

I am confident in my relationships and am able to seek support. (Circle one)

1 2 3 4 5

Disagree Agree

I am interested in further exploring support to help me improve my lifestyle management and achieve my goals. (Circle one)

5 4 3 2 1

Disagree Agree

During the past month, have you experienced feelings of sadness, anxiety or both?

Yes No

Do you experience feelings of sadness or grief?

Yes No

Have you had any significant relationship changes recently?

Yes No

Do you currently use or have you previously used tobacco?

Yes Cigarettes, # of packs/day: _________

Cigars, # per day/week: ___________

Chewing tobacco: ____________

Year quit, if applicable: ___________

No

How many days per week do you drink beer, wine or other alcoholic beverages? ________

How many caffeinated beverages do you drink per day? ________

Do you have a history of chemical dependency?

Yes No

Name ______________________________ DOB ______________

**Medical History**

| ***Please check if you have had:*** | ***Yes*** | ***No*** |
|---|---|---|
| Allergies | | |
| Arthritis | | |
| Bladder problems (including repeated infections, urinary incontinence, leaking) | | |
| Blood disorders (including hemophilia/anemia) | | |
| Bone/joint infections | | |
| Broken bones/fractures | | |
| Cancer | | |
| Circulation/vascular disorders | | |
| Depression or anxiety | | |
| Developmental or growth problems | | |
| Diabetes or problems with blood sugar | | |
| Fibromyalgia | | |
| Head injury | | |
| Heart problems (including pacemaker) | | |
| High blood pressure/hypertension | | |
| Infectious diseases (such as tuberculosis, hepatitis, HIV) | | |
| Kidney problems | | |
| Liver problems | | |
| Lung problems (including asthma) | | |
| Metal implants | | |
| Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio) | | |
| Osteoporosis/osteopenia | | |
| Seizures/epilepsy | | |
| Sensitivity to latex rubber | | |
| Skin diseases | | |
| Thyroid problems | | |
| Ulcers/stomach problems | | |
| Other: ______________________. | | |

*For men:*

Have you ever been diagnosed with prostate disease?

Yes No

*For women:*

Have you ever been diagnosed with:

Pelvic inflammatory Disease?

Trouble with your period?

Endometriosis?

Complicated pregnancies/ deliveries?

Are you pregnant or think you might be pregnant?

Yes No

**Have you ever had surgery?**

Yes No

If yes, please describe and include year:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Has a family member (parent/sibling/grandparent/aunt/uncle) had:**

| | *Yes* | *No* | *Not sure* |
|---|---|---|---|
| Heart disease | | | |
| High blood pressure | | | |
| Stroke | | | |
| High cholesterol | | | |
| COPD/emphysema | | | |
| Diabetes | | | |
| Cancer | | | |
| Psychological disorder | | | |
| Arthritis | | | |
| Osteoporosis/osteopenia | | | |
| Alzheimer's Disease/dementia | | | |
| Depression | | | |
| Other: | | | |

**Within the past year, have you had any of the following medical tests?**

- Angiogram
- Arthroscopy
- Biopsy
- Bone scan
- Doppler ultrasound
- Echocardiogram
- EKG (electrocardiogram)
- EMG (electromyogram)
- MRI
- Myelogram
- NCV (nerve conduction velocity)
- Pulmonary function test
- Stress test (such as treadmill, bicycle)
- X-rays

**Within the past year, have you had any of the following symptoms?**

- Bowel problems
- Chest pain
- Coordination problems
- Chronic cough
- Difficulty sleeping
- Dizziness or blackouts
- Fever/chills/sweats
- General malaise
- Headaches
- Hearing problems
- Hoarseness
- Leg pain with walking
- Loss of appetite
- Loss of balance/falls
- Nausea/vomiting
- Pain during the night
- Sexual dysfunction
- Shortness of breath
- Urinary problems/ change in frequency
- Vision problems
- Weakness in arms or legs
- Weight loss/gain

**Are you currently seeing anyone else for this diagnosis?**

- Acupuncturist
- Athletic trainer
- Cardiologist
- Chiropractor
- Dentist
- Family doctor
- Internist
- Massage therapist
- Neurologist
- Obstetrician/ gynecologist
- Occupational therapist
- Orthopedist
- Osteopath
- Pediatrician
- Podiatrist
- Primary care physician
- Rheumatologist
- Other: ______________

______________________________ ____________

**Signature** **Date**

## Medication Log

Name: ____________________________ Date: _________________

| Medication Name | Taken Orally? | Dosage | Times Per Day |
|---|---|---|---|
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |
| | ☐ Yes ☐ No | | |

Pain Diagram and Pain Rating.

Name: ______________________________ Date: ____/____/____
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. **Be VERY precise when drawing the location of your pain.** Use the key to indicate the type of symptoms.

Key: Pins and Needles = 000000 Stabbing = //////
Burning = xxxxxx Deep Ache = zzzzzz

Please rate your current level of pain on the following scale (check one):

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| (no pain) | | | | | | | | | | (worst imaginable pain) |

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| (no pain) | | | | | | | | | | (worst imaginable pain) |

Please rate your best level of pain in the last 24 hours on the following scale (check one):

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| (no pain) | | | | | | | | | | (worst imaginable pain) |