Confidential Health & Lifestyle Questionnaire

Name	
Address	
Tel. Home	
Mobile	
Email	
Occupation	
Date of Birth	

Doctor's Name	
Address	
Tel.	

Emergency Contact	
Relationship	
Tel. Home	
Mobile	

Health Questionnaire

Have you, or do you suffer from any of the following?

Asthma ☐
Angina ☐
High blood pressure ☐
Low blood pressure ☐
Epilepsy ☐
Arthritis ☐
Constipation ☐
Diabetes ☐
Frequent colds ☐
Dizziness/fainting ☐
Heart disease ☐
Shortness of breath ☐
Rheumatic fever ☐
High cholesterol ☐
Palpitations ☐
Headaches ☐
Migraines ☐
Joint pains ☐

Please provide details where applicable

Have any of your first-degree relatives experienced the following conditions?

Heart Attack ☐ Heart operation ☐ Congenital heart disease ☐ High cholesterol ☐

Have you ever had surgery? Yes ☐ No ☐

If yes, please give details:

PAST INJURIES: i.e. broken bones, sprains etc.

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Do you have any tension or soreness in a specific area? Yes □ No □
If yes, please give details

Do you experience numbness, tingling or stabbing pains anywhere? Yes □ No □
If yes, please give details

Are you sensitive to touch/pressure in any area? Yes □ No □
If yes, please give details

Do you experience stiff, swollen or painful joints? Yes □ No □
If yes, please give details

What is your 'chief complaint?'

Date of onset and duration

What incident do you feel may have caused the problem?

Treatment to date

Previous diagnoses

Does your 'chief complaint' affect you on a day-to-day basis? Yes □ No □
If yes, please give details

Are the symptoms brought on by certain activities? Yes □ No □
If yes, please give details

Do specific activities or positions alleviate your symptoms? Yes □ No □
If yes, please give details

When is the pain worse?

Do you experience fatigue or lack of energy? Yes □ No □

What is your current weight?

Have you had a any of the following: physical therapy, osteopathy, massage therapy, other?Yes □ No □
If yes, please give details

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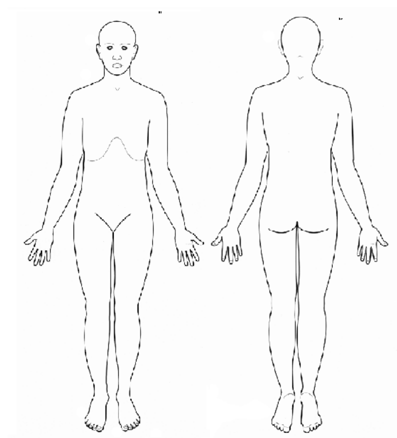
Indicate on the diagrams where you have been experiencing the pain:



Lifestyle Questionnaire

Occupation: Please explain your position along with the physical and mental responsibilities involved

Do you have an ergonomically set up desk/workstation? Yes □ No □
If yes, please give details

How many hours do you spend in front of a computer?

How much time do you spend in a seated position?

On a scale of 1 - 10, circle how active you are on a daily basis (1 not active, 10 very active)
1 2 3 4 5 6 7 8 9 10

How often do you take part in physical activity?
7+ times per week 5-6 times per week 3-4 times per week 1-2 times per week

How long have you been consistently physically active for?

What activities are you presently involved in?

Cardio/Sports	Frequency per week	Average length	Easy/Moderate/Hard

Strength Training	Frequency per week	Average length	Easy/Moderate/Hard

Stretching	Frequency per week	Average length	Easy/Moderate/Hard

List all past activities/other interests. Please also list any competitive events planned/completed with results (use separate sheet if necessary)

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How many hours sleep do you get each night?

Do you consider yourself to be under stress? Yes □ No □
If yes, give details

Do you smoke? Yes □ No □
If yes, how many per day

Do you drink alcohol? Yes □ No □
If yes, how many units per week?

Diet Questionnaire

Do you follow, or have you recently followed, any specific dietary intake plan? Yes □ No □
If yes, please give details

In general, how do you feel about your nutritional habits?

Food Diary Snapshot

Breakfast Time

Snack Time

Lunch Time

Snack Time

Dinner Time

Snack Time

Other Info

How did you find out about my services?

Disclaimer

All the information on this form is correct to the best of my knowledge. I have sought and followed any medical advice where necessary.

Client Signature

Print Name

Date

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