**Health and lifestyle Questionnaire**

**Personal Details**

Name:

Address:

Post Code:

Tel: (H) (W) (M)

Occupation: D.O.B

E-mail:

**Your Doctor’s Details**

Doctors Name: Tel:

Address:

Post Code:

**Emergency Contact Details**

Name:

Address:

Post Code:

Relationship:

Tel: (H) (W) (M)

**Confidential Health Questionnaire**

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

(Please tick & give details where applicable)

|  |  |  |
| --- | --- | --- |
| Asthma | Constipation | Rheumatic Fever |
| Angina | Diabetes | High Cholesterol |
| High Blood Pressure | Frequent Colds | Palpitations |
| Low Blood Pressure | Dizziness/Fainting | Headaches |
| Epilepsy | Heart Disease | Migraines |
| Arthritis | Shortness of Breath | Joint Pain |

If you have ticked one or more boxes please give details:

**Medical History**

Is there a family history of any of the following medical conditions?

Heart Attack Diabetes

Epilepsy Cancer

Congenital Heart Disease High Cholesterol

High Blood Pressure Asthma

Have you ever had surgery? Yes  No

If yes give details

Have you ever broken any bones? Yes  No 

If yes give details

Do you suffer form back pain? Yes  No 

If yes give details

Do you have tension or soreness in a specific area? Yes  No 

If yes give details

Do you experience numbness, tingling or stabbing pains anywhere?

If yes give details

Yes  No 

Are you sensitive to touch/pressure in any area? Yes  No 

If yes give details

Do you experience stiff, swollen or painful joints? Yes  No 

If yes give details

Are these or any other injuries, aggravated by exercise? Yes  No 

If yes give details

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 give details

Are the symptoms brought on by certain activities? Yes  No 

If yes give details

Do specific activities or positions alleviate your symptoms? Yes  No 

If yes give details

When is the pain worse?

Do you experience fatigue or lack or energy? Yes  No 

If yes provide details.

What is your current weight and height?

Have you had any of the following: physical therapy, osteopathy, chiropractic, massage therapy, other?

Please elaborate.

Yes  No 

Please list any medications you are currently taking.

**Confidential Lifestyle Questionnaire**

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

Do you have an ergonomically set up desk/workstation?

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 to 10 (1=not active, 10=very active) please rate how active you are on a daily basis?

How many hours sleep do you get everyday?

Do you consider yourself to be under stress? If yes provide details.

Are you currently involved in any exercise program? If yes please list how long and what type of exercises.

Have you ever had a personal trainer? If yes provide details of when and for how long?

Do you smoke? Yes … No …

If yes, how many per day

Do you follow, or have you recently followed, any specific dietary intake plan, and in general how do you feel about your nutritional habits?

**Daily Dietary Intake**

No. of cups of coffee Amount of sugar

No. of cups of tea Chocolates

Glasses of coke/soda Sweets

Glasses of milk Alcohol

Glasses of water Portions of fruit

Portions of vegetables

Do you have any food intolerances that you know off? Yes … No …

If yes please give details

Do you have any food allergies that you know off? Yes … No …

If yes please give details

Have you ever had a food allergy test? Yes … No …

If yes please give details

**Confidential Goal Questionnaire**

Please list THREE goals in order of importance:

1.

2.

3.

Where are you now in relation to your goals?

How much time are you willing to devote toward achieving this goal?

What is the biggest challenge you must overcome in attaining your goal?

On a scale of 1 to 10 (1=not committed, 10=very committed), please rate how committed you are to achieving your goal?

List three tasks you can do daily, which will help pave the path toward total achievement?

1.

2.

3.

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

All information will be kept confidential.

**Client’s Signature:**

**Date:**