Health and Lifestyle Questionnaire

Name…… Date of birth……

Address……

……

Tel (home)…… (work)…… (e-mail)……

Doctors Name…… Tel……

In case of emergency, whom may we contact?

Name…… Relationship……

Tel (home)…… (work)……

Confidential Health Questionnaire

Please indicate if you currently or have ever suffer from any of the following:

☐ 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

Please provide details……

……

……

Please indicate if any of your immediate relatives have experienced the following conditions:

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

Please answer the following, ticking Yes or No	*Yes*	*No*	*If yes, please provide details*
Have you ever had surgery?	Yes	No	
Have you ever broken any bones?	Yes	No	
Do you suffer from back pain?	Yes	No	
Do you have tension or soreness in a specific area?	Yes	No	
Do you experience numbness, tingling or stabbing pains anywhere?	Yes	No	
Are you sensitive to touch/pressure in any area?	Yes	No	
Do you experience stiff, swollen or painful joints?	Yes	No	

What is your "chief complaint"?

.....

Date of onset & duration.

.....

What incident do you think may have caused the problem?

.....

Treatment to date.

.....

.....

Previous diagnoses.

.....

Does your "chief complaint" affect you on a day-to-day basis?

.....

Are the symptoms brought on by certain activities?

.....

Do specific activities or positions alleviate your symptoms?

.....

When is the pain worse?

.....

Do you experience fatigue or lack of energy? If yes, provide details.

.....

What is your current weight? .....

Have you had any of the following: Physical therapy, osteopathy, chiropractic or massage therapy, other? Please elaborate.

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.....

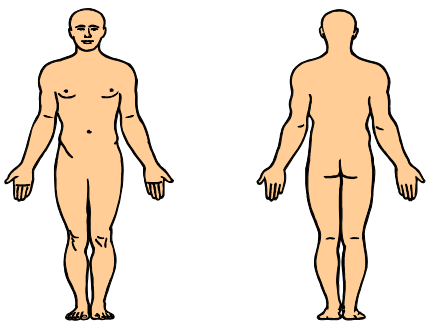
.....

Please list any medications you are currently taking

.....

.....

Please indicate on the diagram where you have been experiencing pain.



Confidential Lifestyle Questionnaire

What is your occupation?

……

……

Do you have an ergonomically set up desk/workstation?

……

How many hours per day do you spend sat at a desk?

……

How much time per day do you spend driving or sitting in a car?

……

On the below scale please indicate how active you are on a daily basis.

Not active 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Very active

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 programme? If yes, what type and for how long?

……

……

Have you ever had a personal trainer? If yes, 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?

……

In general how do you feel about your nutritional habits? Please indicate any concerns.

……

……

Daily Dietary Intake – how much do you consume?

No. cups of coffee	……..	Sugar	……
No. cups of tea	……..	Chocolate	……
No. glasses of milk	……..	Sweets/cakes	……
No. glasses of coke/soda	……..	Alcohol	……
Water	……..	Portions of fruit	……
		Portions of veg	……

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/able to devote toward achieving this goal?

……

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

……

……

On the below scale please indicate how committed you are to achieving your goal.

Not committed 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Very committed

List three tasks you can do daily, which will take you a step closer toward achieving your goal

1. ……
2. ……
3. ……

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

Client name

Client signature

Date