



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)

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> 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?

- | | |
|---|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |

Have you ever had surgery?
If yes give details

Yes No



Have you ever broken any bones?
If yes give details

Yes No

Do you suffer form back pain?
If yes give details

Yes No

Do you have tension or soreness in a specific area?
If yes give details

Yes No

Do you experience numbness, tingling or stabbing pains anywhere?

If yes give details

Yes No

Are you sensitive to touch/pressure in any area?

If yes give details

Yes No

Do you experience stiff, swollen or painful joints?
If yes give details

Yes No

Are these or any other injuries, aggravated by exercise?
If yes give details

Yes No

What is your "chief complaint"?

Date of onset & 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 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 of energy? Yes No
If yes provide details.

What is your current weight?

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

Yes No

Please elaborate.



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 programme? 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?



How did you find out about my services? Give details.

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	<input type="text"/>	Amount of sugar	<input type="text"/>
No. of cups of tea	<input type="text"/>	Chocolates	<input type="text"/>
Glasses of coke/soda	<input type="text"/>	Sweets	<input type="text"/>
Glasses of milk	<input type="text"/>	Alcohol	<input type="text"/>
Glasses of water	<input type="text"/>	Portions of fruit	<input type="text"/>
Portions of vegetables	<input type="text"/>		

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: _____