ALIGN Chiropractic
SPINE & SPORTS REHAB

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PERSONAL TRAINING CLIENT HEALTH HISTORY FORM

Name:_____ DOB:_____ Age:_____
Last First MI

Height:_____ Weight:_____

Home #: _____ Cell #:_____ E-mail:_____

Address: _____ City: _____ Zip:_____

Occupation: _____ Employer:_____ Work #:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated Sex: ☐ Male ☐ Female

Patient Primary Dr.:_____ Name of Practice:_____

Primary Dr. Office Phone #:_____ Date of last physical exam: _____

Does your physician know that you are participating in an exercise fitness program? ☐ Yes ☐ No

Emergency Contact Person:_____ Phone #:_____

Are you taking any medications? ☐ No ☐ Yes (please list medications and reason for usage below)

Medication:	Reason for Usage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you taking any vitamins or nutritional supplements?
☐ No ☐ Yes (please list medications and reason for usage below)

Supplement:	Reason for Usage:
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently under the care of a physician, chiropractor, or other health care professional for any reason? ☐ No ☐ Yes, please list reason:_____

If female, are you currently pregnant? ☐ No ☐ Yes

Section I: General Health

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.		YES	NO
1.	Has your doctor ever said that you have a heart condition OR high blood pressure?	☐	☐
2.	Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	☐	☐
3.	Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4.	Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	☐	☐
5.	Are you currently taking prescribed medications for a chronic medical condition?	☐	☐
6.	Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other.	☐	☐
7.	Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the above questions, please go to section 3.

If you answered YES to one or more of the above questions, please go to section 2.

Section II: Chronic Medical Conditions

Please read the questions below carefully and answer each one honestly: check YES or NO.			YES	NO
1.	Do you have Arthritis, Osteoporosis, or Back Problems?		☐ If yes, answer questions 1a-1c	☐ If no, go to question 2
	1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/ or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	☐	☐
	1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	☐	☐
2.	Do you have Cancer of any kind?		☐ If yes, answer questions 2a-2b	☐ If no, go to question 3
	2a.	Does your cancer diagnosis include any of the following types: lung/ bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck?	☐	☐
	2b.	Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?	☐	☐

3.	Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm		☐ If yes, answer questions 3a-3e	☐ If no, go to question 4
	3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	3b.	Do you have an irregular heart beat that requires medical management? (e.g. atrial fibrillation, premature ventricular contraction)	☐	☐
	3c.	Do you have chronic heart failure?	☐	☐
	3d.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer YES if you do not know your resting blood pressure)	☐	☐
	3e.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	☐	☐
4.	Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes		☐ If yes, answer questions 4a-4c	☐ If no, go to question 5
	4a.	Is your blood sugar often above 100 mg/dL? (Answer YES if you are not sure)	☐	☐
	4b.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet?	☐	☐
	4c.	Do you have other metabolic conditions (such as thyroid disorders, pregnancy- related diabetes, chronic kidney disease, liver problems)?	☐	☐
5.	Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome)		☐ If yes, answer questions 5a-5b	☐ If no, go to question 6
	5a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	5b.	Do you also have back problems affecting nerves or muscles?	☐	☐

6.	Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure		☐ If yes, answer questions 6a-6d	☐ If no, go to question 7
	6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	6b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	☐	☐
	6c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	☐	☐
	6d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	☐	☐

7.	Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia		☐ If yes, answer questions 7a-7c	☐ If no, go to question 8
	7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	7b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	☐	☐
	7c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	☐	☐
8.	Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event		☐ If yes, answer questions 8a-c	☐ If no, go to question 9
	8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	☐	☐
	8b.	Do you have any impairment in walking or mobility?	☐	☐
	8c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	☐	☐
9.	Do you have any other medical condition not listed above or do you live with two chronic conditions?		☐ If yes, answer questions 9a-c	☐ No
	9a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months OR have you had a diagnosed concussion within the last 12 months?	☐	☐
	9b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	☐	☐
	9c.	Do you currently live with two chronic conditions?	☐	☐

Section III: Family History

Father: Current Age:_____ □ Deceased

Father's general health is: □ Excellent □ Good □Fair □Poor

Reason for Fair/Poor health is:_____

Mother: Current Age:_____ □ Deceased

Mother's general health is: □ Excellent □ Good □Fair □Poor

Reason for Fair/Poor health is:_____

Siblings: Do you have any siblings? □ Yes □ No; If yes, do they have any health problems?_____

_____

Section III: Family History (cont'd)

Have any of your BLOOD relatives had:

1. Heart Attack under age of 50? □ Yes □ No
2. Stroke under age 50? □ Yes □ No
3. High Blood Pressure? □ Yes □ No
4. High Cholesterol? □ Yes □ No
5. Diabetes? □ Yes □ No
6. Asthma or Hay Fever? □ Yes □ No
7. Heart Operations? □ Yes □ No
8. Obesity? □ Yes □ No
9. Leukemia or Cancer under age 60? □ Yes □ No

Section IV: Exercise and Physical Activity

For the following questions, please mark which best applies to you.

Are you currently involved in a fitness program on a regular basis? □ Yes □ No

Are you currently involved in daily physical activities (ie. gardening, etc.)? □ Yes □ No
If yes, which activities:_____

Do you participate in any cardiovascular exercise (ie walking, running, sports)? □ Yes □ No
If yes, which activities/sports?:_____

Do you participate in a strength training/weight lifting program? □ Yes □ No
If yes, how often?:_____

Do you consider yourself? □ Sedentary □ Lightly Active □ Moderately Active □ Highly Active

Do you feel that you are physically fit? □ No □ Less than Average □ Average
□ Above Average □ Outstanding □ Don't Know

Indicate the main reason why you currently exercise or want to start an exercise program?
□ It is good for my health □ Stress relief □ Doctor recommended □ Trying to lose weight
□ To feel good □ Other:_____

GOALS:
What goals do you wish to accomplish with your exercise program? _____

_____

_____

Section V: Declaration

Please read and sign the declaration below:

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. In addition, by signing this form I am giving permission and consent for my participation in an exercise program as recommended by Align Chiropractic Spine & Sports Rehab.

NAME:_____ DATE: _____

SIGNATURE:_____

WITNESS:_____