Name_____ Birth Date _____ Date _____ Health History/Contact Information

1. How would you describe your present state of health? **Poor, Fair, Good, Very Good, Excellent** (*circle one*)

2. List any prescription or over-the-counter medications you are currently taking.

_____

3. Have you had surgery in the past 3 months? YES/NO List all past surgeries.

_____

4. Have you had a bone-density test (BMD Bone Mineral Density) and if so what were the results of the test?

_____

5. Do you struggle with disordered eating (Bulimia, Anorexia, Binge eating, etc.)? Please list and explain.

_____

6. Are you experiencing Menopausal symptoms? (Please list all symptoms and explain in detail) ___

_____

7. List hobbies, sports activities and exercise you participate in on a regular basis.

_____

_____

Family History. Has anyone in your immediate family been diagnosed with any of the following - heart disease, high cholesterol, high blood pressure, cancer, diabetes, or osteoporosis? If yes, please explain below:

_____

_____	_____	_____
Name (Print)	***Street Address***	***City/State/Zip Code***
_____	_____	_____
Phone	***Email***	***Occupation***
_____	_____	
Emergency Contact	***Emergency Contact Phone***	

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Name_____ Birth Date _____ Date _____ Health History/Contact Information

Please check any that apply to you.

___ Age 50+
___ Bone or Joint Pain (e.g. arthritis)
___ Knee or Hip Replacement
___ Pregnant within the last 3 months
___ Smoking habit (now/past year)
___ Osteoporosis
___ Anemia
___ Anxiety
___ Asthma
___ Celiac Disease
___ Chronic Sinus Condition
___ Chronic Constipation
___ Crohn's Disease
___ Plantar Fasciitis/Foot Condition
___ Diabetes
___ High Cholesterol
___ Chronic Diarrhea
___ Fibromyalgia
___ High Blood Pressure
___ Hypoglycemia
___ Gastroesophageal Reflux Disease
___ Insomnia
___ Intestinal Problems
___ Lupus
___ Parkinson's Disease
___ Premenstrual Syndrome (PMS)
___ Ulcer
___ Depression
___ Post-Traumatic Stress Disorder
___ Skin problems
___ Hypo/Hyperthyroidism
___ Allergies – specify below
___ Cancer – specify below
___ Heart Condition
___ Chest Pain
___ Pelvic Floor Dysfunction
___ Urinary incontinence
___ Overactive Bladder
___ Overweight (20 pounds or more)

Describe any other health conditions you have that are not listed above:

_____

_____

_____

_____

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