HEALTH AND LIFESTYLE QUESTIONNAIRE

NAME: ..... **D.O.B** _____

ADDRESS .....

.....

TEL (H): ..... **(W):** ..... **E.MAIL:** .....

Doctors Name: ..... **Tel:** .....

In case of emergency, whom may we contact?

Name: ..... **Relationship:** .....

Tel: (H): ..... **(W):** .....

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 ☐

DETAILS: .....

.....

.....

Have any of your first-degree relatives experienced the following conditions?

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

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 from 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? Yes ☐ No ☐ If yes give details.

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.

What is your main complaint?

Date of onset & duration

What incident do you feel may have caused the problem?

Treatment to date

Previous diagnoses

Does your main 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? 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.

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/tea		Spoons of sugar	
Water (litres approx)		Red Meat	
Coke or other Soda		White Meat or Fish	
Portion of green veg		Oily Fish	
Portion of starchy veg		Takeaway	
Portions of fruit		Alcohol units	

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.

Client's Signature: ..... Date: .....