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Medical History & Lifestyle Questionnaire

All medical and lifestyle information received on this form will be treated as strictly confidential. Please fill out the forms as accurately as possible. This information is essential to develop a program that addresses your needs, goals and interests and also ensures that your program is safe and effective.

Client Name: _____ Emergency Contact: _____

Date of Birth: _____ Emergency Phone #: _____

Address: _____

Home Phone #: _____ Cell #: _____

Email: _____

Family Physician: _____ Physician's Phone #: _____

Lifestyle Evaluation

What is your occupation? _____

How much do you work: ◯ Part-time ◯ Full-time

On average, how many hours of sleep do you get a night? _____

Which do you eat regularly?

☐ Breakfast ☐ Midafternoon snack

☐ Midmorning snack ☐ Dinner

☐ Lunch ☐ After-dinner snack

Have you ever participated in a structured diet? ◯ Yes ◯ No

If yes, please give details. (i.e. name of diet, how long did you follow it for, weight lost)

How many times a week do you currently take part in physical activity? _____

What sort of activities do you most often take part in? (i.e. walking, running, cycling, gardening, weight training, etc....)

Medical History

Weight: _____ Height: _____

Are you currently under a physician's care? ◯ Yes ◯ No

If yes, what for? _____

Are you pregnant now or have given birth within the last year? ◯ Yes ◯ No

Have you experienced any pelvic floor issues past or present (i.e. pain, incontinence, prolapse)? ◯ Yes ◯ No

If yes please explain: _____

_____

Select any of the following for which you've been diagnosed:

☐ Kidney problem	☐ Muscle problem	☐ Hypertension	☐ Osteoporosis	☐ Fractures
☐ Heart problem	☐ Joint problem	☐ High Cholesterol	☐ Cancer	☐ Disc Problems
☐ Stroke	☐ Epilepsy	☐ Diabetes	☐ Arthritis	☐ Other:_____
☐ Concussion	☐ Liver problem	☐ Respiratory problem	☐ Depression	

Please explain (i.e. when diagnosed, stage of progression, and if relevant the affected area):

_____

_____

Are you presently on any medication? ◯ Yes ◯ No

Please list any medications, or supplements you've taken in the last 6 months:

_____

_____

Are you allergic to any medications, foods or other substances?

_____

_____

List any surgeries you've had in the past? (E.g. heart, knee, back, c-section, etc...)

_____

_____

Have you ever had severe dizzy spells or fainting episodes? _____

Do you have any other medical conditions or health problems which may affect your safety or ability to exercise in any way? If yes, please explain:

_____

_____

_____

Present Condition

What is your primary complaint: _____

When did this complaint start: _____

Is this complaint an ICBC or WorkSafe BC claim: ◯ Yes ◯ No

What makes this condition feel worse: _____

What makes this condition feel better: _____

Have you had previous treatment for this condition: ◯ Yes ◯ No

If yes, please explain (i.e. type of treatment, duration, results): _____

_____

What are your health & fitness or rehabilatative goals with Kinesiolgy? _____

Referred By: _____

I have read and understood the above information and provided honest answers to the best of my ability regarding my lifestyle and current medical status.

Signature: _____

Date: _____