Client Name _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____)_____

Email_____

Emergency Contact _____ Emergency Contact Phone (____)_____

{} Male {} Female Date of Birth ____/____/_____ Occupation _____

Exercise Activities _____

Short-Term Client Goals: _____

Long-Term Client Goals: _____

Health History Questionnaire
Check all of the following that apply:

{}Pregnant	{}Herniated disc	{}High blood pressure	{}Nervousness
{}Low back pain	{}Nonunion fracture	{}Low blood pressure	{}Depression
{}Mid back pain	{}Insomnia	{}Poor Circulation	{}Dizziness
{}Tight shoulder	{}Fibromyalgia	{}Numb hands/feet	{}Chronic Fatigue
{}Stiff neck	{}Hernia	{}Recent Injury	{}Occupational Stress
{}Feet pain	{}Arthritis	{}Stroke	{}Physical Stress
{}Joint pain	{}Bursitis	{}Seizures	{}Emotional Stress
{}Sciatic pain	{}Allergies	{}Tuberculosis	{}Diabetes
{}TMJ pain	{}Sinusitis	{}Cerebral Palsy	{}Hepatitis
{}Headaches	{}Asthma	{}Digestive disorders	{}Thyroid disease
{}Edema	{}Skin disorders	{}Constipation	{}Heart disease
{}Recent surgery	{}Varicose Veins	{}Ulcers	{}Multiple Sclerosis
{}Cancer	{}Phlebitis	{}Anemia	{}Parkinson's disease

Are you currently under a physician's care? {} yes {} no If so, for what condition(s)?_____

_____

What medications, if any, are you taking? _____

List significant injuries and surgical operations with approximate dates: _____

_____

List current pain, discomfort, complaints: _____

_____

How did you hear about us? _____

I have stated all medical conditions that I am aware of and will keep Journeys Fitness and Wellness, Inc informed with any changes. I understand that JFAW services are not a substitute for care by a physician. I further understand this information is provided to assist the JFAW staff in providing appropriate care and service, which is not to be construed as medical treatment except as specifically prescribed by a physician. I agree to provide a 24-hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee.

Client Signature _____ Date _____