ATHLETE HEALTH HISTORY PROFILE

Name _____ Date _____
DOB _____ Height _____ Weight _____
Phone _____ Email _____

Illnesses/Conditions:

Have you ever been told by a physician, as a result of medical or lab testing, x-rays, or other diagnostic modalities, that you have or have had the following:

- ❑ Arthritis
- ❑ Allergies (list)
  _____
  _____
- ❑ Asthma/Exercise Induced Asthma
- ❑ Autoimmune Disease (Type)
  _____
- ❑ Cancer (Type)
  _____
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Fatigue Syndrome
- ❑ Chrohn's/Colitis
- ❑ Depression or Anxiety
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Epiliepsy
- ❑ Gastric Reflux
- ❑ Heart Abnormality (Type)
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Infection, Chronic (Type)
  _____
- ❑ Irritable Bowel Syndrome
- ❑ Kidney/Bladder Disease
- ❑ Migraine Headaches
- ❑ Neurological Disease (Type)
  _____
- ❑ Stroke
- ❑ Temporomandibular Joint Syndrome (TMJ)
- ❑ Thyroid Disease (Type)
  _____
- ❑ Ulcer

Have you experienced a concussion?
How many? _____
Other (list) _____
_____

Lifestyle:

Are you a student or professional/elite athlete? _____
Do you smoke? _____ Have you ever smoked? _____ How long? _____
Do you drink alchoholic beverages? (frequency/amount) _____
Describe eating habits (healthy, organic, fast/junk foods, skip meals, etc.) _____

How many hours of sleep per night? _____ Do you wake up rested? _____

Sport:

What sport/s do you currently play? _____ Position _____
In what sports or hobbies have you participated in the past? _____
Training schedule (Type, frequency, duration):

Injuries, sport and non-sport-related (list all)

Type	Date	Treatment	Result

Surgeries (list all)

Type	Date	Treatment	Result

Motor vehicle accidents

Date	Driver/Passenger	Treatment for injury?

Do you currently use any support/pain relief devices?

Orthotics _____
Braces _____
Sleeves _____
Other _____

Dental Work:

Braces _____ How Long? _____ Head gear/Palate expander? _____
Wisdom Teeth Removal? _____
Other _____

Do you clench or grind your teeth? _____ **Mouthguard?** _____

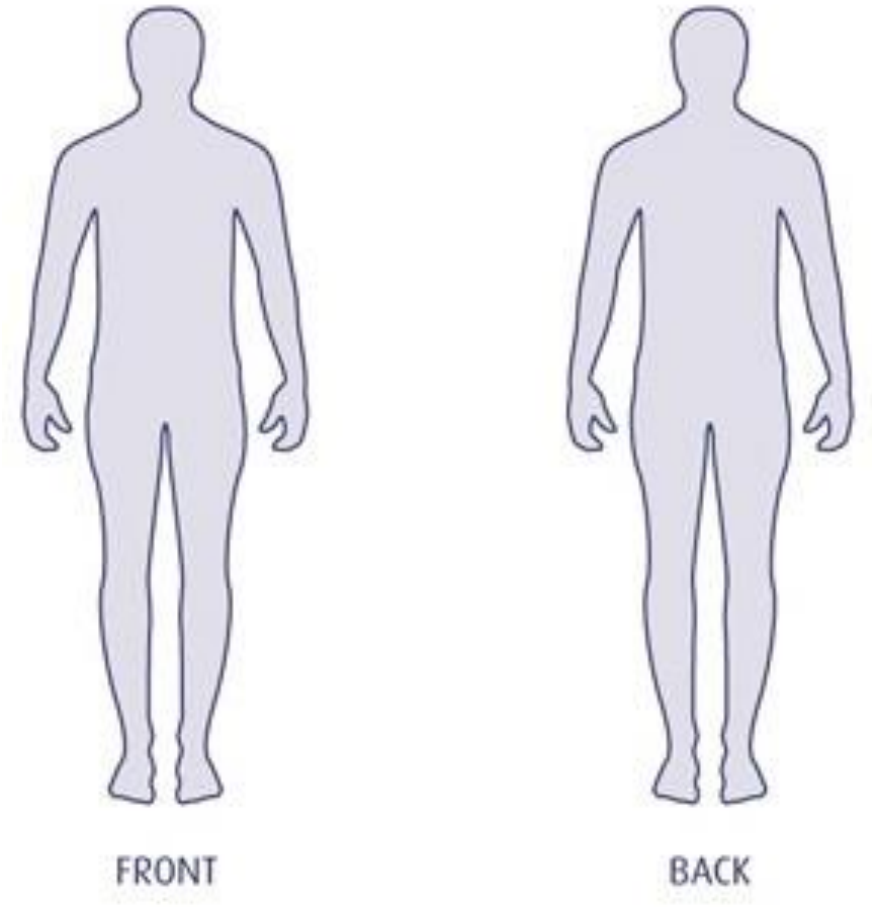
Medications, prescription or non-prescription

Name	Dosage	To Treat

Supplements, Vitamins, Herbal Remedies

Name Dosage To Treat

Use the outline below to circle any parts/areas you're currently experiencing pain or weakness:



Physician Name/Contact:

Emergency Contact:

Address, phone, relationship: