Name_____ **Date**_____
Age_____ **Phone**_____ **email**_____
DOB _____ **Address** _____

HEALTH HISTORY AND WELLNESS QUESTIONNAIRE

This questionnaire covers several areas pertaining to your general health and its relationship to your neuromuscular system's functionality. Please take time to fill this form out as completely as possible. Having comprehensive information on our clients ensures we can use the best possible approach in addressing your needs.

Illnesses

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 the following:

Arthritis ☐
Allergies (list)

_____

_____

Asthma/Exercise-induced Asthma ☐

Alzheimer's Disease ☐
Autoimmune Disease (type)

_____

Chronic Bronchitis/COPD ☐
Cancer (type)

_____

Carpal Tunnel Syndrome ☐
Chronic Fatigue Syndrome ☐

Crohn's/Colitis ☐
Depression ☐
Diabetes (type)

_____

Eating Disorder ☐
Epilepsy ☐
Emphysema ☐
Environmental Sensitivities ☐

Fibromyalgia ☐
Gastric Reflux Disease ☐
Gout ☐
Heart Disease ☐

High Blood Pressure ☐
High Cholesterol ☐

Infection, Chronic (type)

_____

Irritable Bowel Syndrome ☐
Kidney/Bladder Disease ☐

Liver/Gall Bladder Disease ☐
Mental Illness ☐

Migraine Headaches ☐
Neurological Disease (type)

_____

Obesity ☐
Osteoporosis ☐
Pneumonia ☐

Sexually Transmitted Disease ☐
Stroke ☐
Temporomandibular Joint Syndrome (TMJ) ☐
Thyroid Disease (type)

_____

Ulcer ☐
Other (list)

_____

_____

For Women Only

Menstrual Irregularities ☐
Endometriosis/Fibroids ☐
Breast Cancer ☐
Pelvic Inflammatory Disease ☐
No. of pregnancies _____
No. of children _____
Vaginal Births _____ C-Section Births _____

For Men Only

Prostate Enlargement ☐
Prostate Cancer ☐

Lifestyle

What do you do for a living? _____
Do you smoke? _____ Have you ever smoked? _____ How Long? _____
Do you drink alcoholic beverages? (frequency, amount) _____
Do you use caffeine? (type, frequency, amount)_____
How would you describe your eating habits? (do you eat regular meals, snack, eat all organic, all fast food, etc.) _____
How well do you sleep at night? _____

Exercise

Frequency ___ 1-2 days/week ___3-4 days/week ___5-7 days/week
Duration ___ less than 30 min. ___ 30-60 min. ___more than 60 min.
Type: (list all types of exercise, i.e., walk, run, elliptical, cycling, weights, pilates, yoga, etc.)

Medications and Supplements

Are you currently taking any prescription or non-prescription medications?

Name	to treat	dosage

Are you currently taking any nutritional supplements (vitamins, minerals, enzymes, herbal remedies)?

Name	to treat	dosage

Injuries and Surgeries

Please list all injuries, current or former, as far back as you can remember. Please include falls, cuts/burns, even if you did not receive professional treatment for the injury. Please list all surgeries. (females, please include cesarean sections)

Injury/Surgery	Date	Treatment	Result

Motor vehicle accidents

Please list car accidents, whether minor or major, that you have been involved in.

Date	Driver/Passenger?	Treatment for injury?

Do you currently use any devices for support/pain relief (orthotics, knee brace, waist belt, etc.) _____

Dental Work

Please list any form of extensive dental work, dental surgery, maxillofacial surgery or periodontal work you have had done, including braces, wisdom tooth extraction, etc.

Procedure	Date	To Treat	Result

Do you clench or grind your teeth? _____

Personal Stress

On a scale of 1 to 5, 1 being not stressful at all and 5 being very stressful, how would you rate the following:

My job/occupation: _____

My finances: _____

My personal relationships: _____ (spouse/partner, children, parent/s, friends, workplace)

My health: _____

My life: _____

What is your primary reason for seeking Muscle Activation Techniques/what is your primary complaint for which you are seeking help?

Are there any other problems, conditions or items you think may be helpful in providing proper evaluation and assistance to you? _____
_____

Name of physician _____

Practice Name/phone _____

In case of emergency, contact:

Address/phone: _____
Relationship

Who referred you to us?
