Optimum Health & Exercise Therapy

Health and Fitness Evaluation

Date:__________

Name______________________________Occupation:___________________

Address_________________TOWN/ZIP___________Phone__________________

Age______ DOB_______ Height________ Weight_________

Describe any previous Accidents, Injuries or Illnesses____

____

Have you ever had surgery? If yes, please describe.______________

____

Currently taking Medication?____ Name and Dosage________________

Name of Treating Physician_______________________________________

Do you smoke, if yes, how much per day?_________________________

Family History; is there Cancer, Diabetes, Respiratory Illness or Coronary Artery Disease present in any immediate family member?

____

What three things would you do in your life to be healthier?:____

Blood Pressure Reading:_________ Resting Heart Rate:_________

Water Intake:______< or > 50oz per day (approx 8 glasses)

What type of exercise do you regularly perform?________________

Have you ever had a spinal wellness evaluation?________________

Have you ever been in a massage therapy program?_______________

Do you consider yourself healthy, somewhat healthy, or unhealthy? Please explain____

____

(Over)

Do you have minimal, moderate, or considerable stress in your life?____

Do you take vitamins or other supplements? (if so, please list)

____

What is your total cholesterol?__________________________

Describe an average daily diet that is typically consumed (include any alcohol consumption), please list below.

DAILY DIET LISTING

Breakfast:____

____

Lunch:____

____

Dinner:____

____

Alcohol Consumption, list quantity and frequency in a week.____

Any type of food you either dislike or never eat?____

____

What type of foods are your favorites?____

____