



## HEALTH HISTORY QUESTIONNAIRE

|  |                                     |
|--|-------------------------------------|
| Name   |                                     |
| Date   |                                     |
| Address  |                                     |
| Phone  | <u>Home</u> <u>Work</u> <u>Cell</u> |
| E-mail   |                                     |
| Date of Birth  |                                     |
| Occupation   |                                     |
| How did you learn of us?   |                                     |
| Activities/Exercise<br>(frequency/level)                         |                                     |
| Please list any current<br>significant health<br>concerns        |                                     |
| What would you like to<br>achieve from our sessions<br>together? |                                     |

\_\_\_\_\_ Date

\_\_\_\_\_ Please print your name on the above line

\_\_\_\_\_ Signature