The Personal Edge, LLC.

Health History Questionnaire

Name: ______________________________ Ht:______ Wt:_______

Age: ___ Birthdate: _________ Occupation:___________

Address: ________________________ Email: ______________________

City: _______________ State: _____ Zip: _______ Phone: ______________

Emergency Contact: ______________________ Phone: _______________

Personal Physician: ________________________ Phone: ___________

Medical:

Diabetes Epilepsy High Blood Pressure Asthma

High cholesterol Arthritis Pregnant Heart

Orthopedic:

Back: Hips:

Neck: Shoulders:

Knees: Other:

Are you currently taking any medications? Yes No

Are you undergoing treatment with PT, Chiropractor, Massage? Yes No

What is your current exercise level?

Special diet:

Exercise goals:

Click here to e-mail form to Deb