



Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Last First MI  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

For office use only: Height: _____ Weight: _____
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1. Please check any of the following acute or chronic conditions that apply to you.

	Y	N		Y	N		Y	N
Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing/ coughing	<input type="checkbox"/>	<input type="checkbox"/>
Mid back pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Aids	<input type="checkbox"/>	<input type="checkbox"/>
Faint/ Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramping	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/ tingling	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>

2. Please list your primary care physician: \_\_\_\_\_

Are you currently under the care of the above or any other physician or health care professional? Circle one: yes no

For what reason(s)

1. \_\_\_\_\_
2. \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

3. Please list major surgeries and dates:

1. \_\_\_\_\_
2. \_\_\_\_\_

4. Are you currently taking any medications?

Prescriptive Y N List: \_\_\_\_\_

Non- Prescriptive Y N List: \_\_\_\_\_

5. Do you smoke? Y N How many packs per week? \_\_\_\_\_

6. Do you use alcohol? Y N How many drinks per week? \_\_\_\_\_

7. I exercise \_\_\_\_\_ a week for \_\_\_\_\_ minutes. I stretch \_\_\_\_\_ daily/weekly.

8. I drink \_\_\_\_\_ glasses of water a day. My diet is low \_\_\_\_\_ high \_\_\_\_\_ in fats.

9. Are you participating in a supervised diet program? Yes No

10. Would you be willing to do a dietary program through Kronos? Yes No

I acknowledge that the information given above is an accurate account of my medical history and is intended for the sole use of developing a safe and effective fitness program by FitLife Health Systems.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_