

Health & History Questionnaire

Name: _____ Date: _____

1.Occupation:

2.History of Accidents (Childhood, Broken Bones, Stitches, Anytime Hurt Back/Neck, Car Accidents):

3.Surgeries:

4.Medications – Please list medication and condition

5. Vitamins / Supplements:

Do you think you may need vitamins or minerals?

6. What do you do to take care of yourself?:

Do You Exercise?:

How would you rate your nutrition?: Poor Fair Good Excellent

Are you interested in weight loss?

How do you reduce Stress?(prayer, meditation, quiet time):