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THERAPEUTIC EXERCISE HISTORY FORM

NAME _____ DATE _____

ADDRESS _____ ZIP _____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

PHONE (H)_____ (W)_____ (C) _____

E-MAIL _____ REFERRED BY _____

Primary Care Physician _____ Phone _____

Please list your 3 primary health concerns in priority order (ie. musculoskeletal complaints, headache, neck/mid back/low back pain, arm/leg pain, specific injury or weakness)

1. _____

2. _____

3. _____

Additional concerns _____

List any supplements you are currently taking _____

_____

List any medication you are currently taking _____

_____

List any conditions that you have been diagnosed with _____

_____

Have you followed any specific nutrition, diet or exercise programs (past or present) and how well did they work for you? Ie. Atkins, Zone, Weight Watchers, Curves, Golds Gym etc. How much do you exercise? Please list and comment.

_____

CONGRATULATIONS !! YOU HAVE TAKEN A MAJOR STEP TOWARD IMPROVING YOUR HEALTH AND INCREASING YOUR QUALITY OF LIFE!!

BETTER HEALTH THROUGH CHIROPRACTIC, MASSAGE THERAPY, EXERCISE AND CLINICAL NUTRITION