IRON+SALT FITNESS

Health History Form

Name:_____**Date:**_____**Phone Number:**_____**DOB:**_____

Address:_____ **Cell Phone Number:**_____

Contact in case of emergency:_____**Phone Number:**_____

1. Do you have any limitations or conditions to the following that could limit physical activity? Check all that apply:

[ ] Ankle/Foot	[ ] Shoulder/Clavicle	[ ] Low Back Pain/stiffness	[ ] Elbow/Arm
[ ] Arthritis	[ ] Knee/Leg	[ ] Hip/Pelvis	[ ] Head/Neck
[ ] Wrist/Hand	[ ] Upper Back	[ ] Nerve Damage	[ ] Other

Please explain limitations/conditions to any boxes checked:_____

2. Have you broken any bones and/or had any sprains or strains? If so, please list:_____

3. Do you now, or have had in the past:

	YES	NO
• History of heart problems, chest pain, or stroke	[ ]	[ ]
• Increased blood pressure	[ ]	[ ]
• Any chronic illness or condition	[ ]	[ ]
• Difficulty with physical exercise	[ ]	[ ]
• Advice from physician not to exercise	[ ]	[ ]
• Surgery in last 12 months	[ ]	[ ]
• History of breathing or lung problems	[ ]	[ ]
• Muscle, joint, or back disorder, or any previous injury still affecting you	[ ]	[ ]
• Diabetes or thyroid condition	[ ]	[ ]
• Cigarette smoking	[ ]	[ ]
• Increased blood cholesterol	[ ]	[ ]
• Hernia or any condition that may be aggravated by lifting weights	[ ]	[ ]

Please explain any "YES" answers:_____

4. Are you currently taking any medication or drugs? If so, please list medication, dose, and reason:_____

5. Are you presently receiving physical therapy? If so, please explain:_____

6. Have you been hospitalized for surgery or injury? If so, please explain:_____

_____

_____

7. Do you currently exercise? If so, what is your current routine and frequency?_____

_____

_____

8. Occupation:_____ **9. Hours a day seated:**_____ **10. Last physical:**_____

11. Last full blood panel:_____ **12. Hours of sunlight a week:**_____

13. Water intake per day in ounces:_____ **14. Energy level on 1-10 scale (10 is high):**_____

15. Do you feel like stress is a problem in your life? If so, please explain:_____

_____

_____

16. Are you interested in a nutrition program? Please explain your current diet:_____

_____

_____

17. What minerals, herbs, supplements, and/or vitamins are you currently taking?_____

_____

_____

18. What are your goals?_____

_____

_____

_____

_____

_____

Pregnancy:

1. Are you currently pregnant:_____

2. Have you been pregnant:_____

3. Did you deliver vaginally or c section:_____

4. Are you aware of any abdominal separation or any other issues with your pelvic floor?_____

_____

_____

5. Have you done any pelvic floor physical therapy? If so, please explain:_____

_____

_____