HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions as accurately as possible:

1. Do you have any physical limitations? ☐ Yes ☐ No
   Explain: _____

2. Do you have or have you had any neck, back, or extremity injuries or strains? ☐ Yes ☐ No
   Explain: _____

3. Do you have or have you had any heart, vascular, blood pressure, cholesterol, or triglyceride problems? ☐ Yes ☐ No
   Explain: _____

4. Do you have asthma or other bronchial / pulmonary / respiratory conditions? ☐ Yes ☐ No
   Explain: _____

5. Are you diabetic or hypoglycemic? ☐ Yes ☐ No
   Explain: _____

6. Have you had any surgery within the past two years? ☐ Yes ☐ No
   Explain: _____

7. Have you been to physical therapy before? ☐ Yes ☐ No
   Explain: _____

8. Do you smoke? ☐ Yes ☐ No

9. Are you taking any medications? ☐ Yes ☐ No
   If yes, please list all medications and dosages:

_____
_____
_____

10. Do you have any conditions not listed? ☐ Yes ☐ No
    If yes, please list: _____

_____ _____
Signature Date