

Akasha Body Basics

Health History and Lifestyle Questionnaire

Section 1:

Name: _____ Date: _____ Email: _____
Birth Date: (mm/dd/yy) _____ Age: _____ Height: _____ Weight: _____ [] male [] female
Street Address: _____ City: _____ State: _____ Zip: _____
Home phone: (____) _____ Work phone: (____) _____ Cell/pager: (____) _____
Employer: _____ Occupation: _____
Spouse's name: _____
Children's name(s) _____
Medical Doctor: _____ Phone: (____) _____ Referred by: _____

Section 11:

Describe your primary reason for coming here. If your primary reason includes symptoms, please detail.

List your goals for consultation or instruction: 1. _____
2. _____ 3. _____

Section 111:

If your primary concern is due to discomfort, pain or injury, please complete the following section. If not, then skip to Section 1V.

Date pain /injury: _____ Date symptoms first appeared: _____

Level of pain on a scale from 1-10, with 1 being least and 10 being excruciating: _____

Circle words that best describe the pain:

- Sharp Tingling Aching
Dull Numb Variable
Burning Constant Radiating
Localized Nagging No pain, but stiffness

Factors that aggravate your pain (positions/activities): _____

Factors that relieve your pain (positions/activities): _____

Time of day when pain is most apparent: _____

Do you have any functional limitations in your daily routine, work or recreational activities? on sey

If yes, describe: _____

Have you ever been knocked unconscious? yes no

Section IV

Year of last: physical exam _____ X-ray _____ blood test _____

Is your blood pressure normal / high / low ? (circle one)

Check each applicable box for conditions you have currently (C) or have had in the past (P):

C	P	C	P	C	P	C	P
aimena	<input type="checkbox"/>	setebaid	<input type="checkbox"/>	ailihpomah	<input type="checkbox"/>	oilop	<input type="checkbox"/>
sitacidneppa	<input type="checkbox"/>	redrosid gnitae	<input type="checkbox"/>	sititapeh	<input type="checkbox"/>	reveh citamuehr	<input type="checkbox"/>
sitirhra	<input type="checkbox"/>	snoitcefní rae	<input type="checkbox"/>	VIH	<input type="checkbox"/>	redrosid enips	<input type="checkbox"/>
amhtsa	<input type="checkbox"/>	amesyhpme	<input type="checkbox"/>	noisnetrepyh	<input type="checkbox"/>	ekorts	<input type="checkbox"/>
sitisrub	<input type="checkbox"/>	yspelipe	<input type="checkbox"/>	aimecylogopyh	<input type="checkbox"/>	redrosid dioryht	<input type="checkbox"/>
recnac	<input type="checkbox"/>	ai glaymorbif	<input type="checkbox"/>	enummiotua rehto/supul	<input type="checkbox"/>		
sisohrric	<input type="checkbox"/>	smelborp toof	<input type="checkbox"/>	eniargim	<input type="checkbox"/>		
eugitaf cinorhc	<input type="checkbox"/>	amocualg	<input type="checkbox"/>	sisorelcs elpittum	<input type="checkbox"/>		
sitiloc	<input type="checkbox"/>	tuog	<input type="checkbox"/>	smotpmys lacigoloruen	<input type="checkbox"/>		
noisserped	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	sisoropoetso	<input type="checkbox"/>		

List any other significant physical injuries (bone fractures, motor vehicle accidents), pregnancies/childbirth (if applicable), hospitalizations, surgeries or other health-related events and mental illness:

Date	Age	Condition	Treatment	Outcome / Results
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List all non-prescription medications (pain relievers, laxatives, antacids, natural remedies, herbs, etc.) currently taking:

Name	Frequency	Name	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently seeing any other health related practitioner(s)? If so, please describe nature of therapy and list practitioner's name:

Do you participate in any other form of exercise? Yes / No

If Yes, please describe: _____

Usual work activity _____ active sedentary

Describe your energy level: **low** 1 2 3 4 5 **high**

Check if you wear: contact lenses glasses orthotics dentures/bridge pacemaker prosthesis

Women Only

Are you pregnant? Yes No Not sure

Describe any complications: _____

Birth control, if any: _____