Golf MATchanics -- Health History Questionnaire

Today's Date _____/_____/_____
Name _____ Gender: M F DOB ____/____/____ Age ____
Mailing Address _____ Email _____
Home Phone (_____) ____-_____ Work Phone (_____) ____-_____ Pager/Cell (_____)____-_____
Emergency Contact Person _____ Phone (_____) ____-_____

THANK YOU FOR TAKING TIME TO COMPLETE THIS QUESTIONNAIRE. Please answer each question carefully and completely. This is very important information and will contribute significantly to the development and implementation of your personal health and fitness program. If you have any questions please do not hesitate to ask your specialist -_____ Phone (_____) _____-_____

PART 1 – Medical History

1. Who are your primary and secondary care medical providers? (Family physician, OBGYN, internist, psychiatrist, chiropractor, etc.) Please include full name, address and reason for seeing the provider.

Name	Address and Phone	Care Provided

2a. Please list any medications you are currently taking. (Use reverse side of page if needed)

Name of medication	Dosage	Why & How long have you been taking this medication?

2b. Please list any meds you have taken in the past for more than six months but no longer take and why start and stop.

3. Do you take ***any*** nutritional/dietary supplements? If so, please list below.

Name of Supplement	Dosage	Why & How long have you been taking this supplement?

4. Do you now have or in the past suffered from any of the following? :

	YES	NO
a. Has your Doctor said or do you have a history of heart problems, chest pain or stroke		
b. Has an immediate family member (parent/sibling) had a heart attack, stroke or cardiovascular disease before the age of 55 yrs old?		
c. Do you frequently have pains in your heart and/or chest when you do physical activity?		
d. Do you lose balance because of dizziness or do you ever lose consciousness?		
e. Is your doctor(s) currently prescribing drugs for blood pressure or heart condition? See Quest #2		
f. Are you over the age of 65 and not accustomed to vigorous exercise?		
g. High Cholesterol or HDL:LDL imbalance		
h. Do you currently smoke? Cigarette, cigar, pipe smoking How Much How Long		
i. Obesity		
j. Asthma or Breathing trouble		
k. Have you ever had a stroke or heart attack?		
l. Are you a male greater than 45 yrs old? Are you a female greater than 55 yrs old?		
m. (Females) Pregnancy currently or within last 12 months		
How many children have you had?		
n. Learning disabilities or cognitive challenges		
o. Do you consume any alcoholic beverages? (Beer, wine, liquor, etc.)		
Please indicate in ounces how much alcohol you consume weekly (include beer, wine, liquor)		oz
p. Do have difficulty swallowing food or chewing food?		
q. Is there any reason not mentioned thus far to preclude you from regular exercise activity?		
r. Do you have urinary incontinence?		

Please elaborate here if you checked "yes" for letters a, c, d, j, n, and o.

_____

_____

_____

_____

Do you use any non-prescription drugs (marijuana, cocaine, etc.)

_____

5. Please provide your most recent blood panel and any radiological reports you may have from x-rays or MRI's.

Please complete the following information as completely and thoroughly as possible. This is an extremely important section of this questionnaire.

Body Part	1-18 years	19 - 29 years	30 – 45 years	46 - 60 years	60 + years
Head/Jaw i.e. Clicking jaw, concussion,					
Cervical/ Neck i.e. whiplash,					
Thoracic/ Mid back Chest					
Lumbar/ Low back					
Abdominals/ Ribs Hernia					
Pelvis/Hips Joint Femur/Thigh					
Knees Patella, ACL, Tendonitis					
Ankle, Feet Toes,Plantar Fasciitis, Bunion Orthotics					
Shoulder/ Scapulae/ Collar bone Rotator cuff					

Body Part	1 -18 years	19 - 29 years	30 – 45 years	46 - 60 years	60 + years
Elbow i.e. tennis elbow					
Wrist/Hand Fingers Carpal Tunnel					

7. Have you had any cosmetic/plastic surgery? Please describe below. (breast augmentation, tummy tuck, botox)

_____

_____

_____

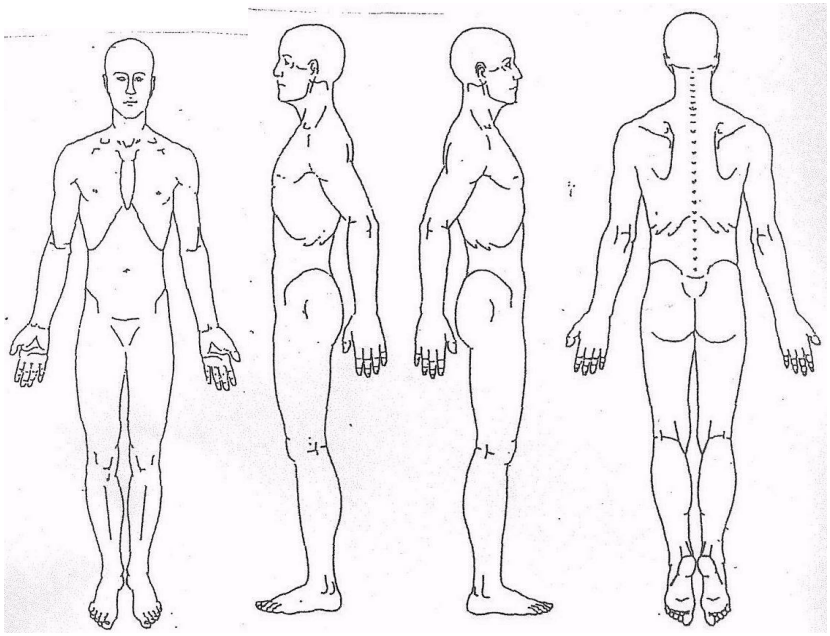
_____

8. *Diagnosed Diseases* **Please Provide all medical reports (X-rays/MRI/CT Scan)**	***Initial Diagnosis Made***
Orthopedic (i.e. Spinal fusion, Knee joint replacement)	
Metabolic (i.e. Diabetes, Hypothyroid)	
Neurological (i.e. Stroke, Parkinson's)	
Dental Work (Braces/Night Bite Plates, Appliances, orthodontics)	

9. What is your Occupation?	How Long Under this Stressor? (In Years)
Physical - Sitting, Standing, Positional How Long/Day? _____	
Emotional - Hi Pressure, Boring, Intermittently Hi & Lo Pressure	

10. ***Please prioritize the severity (#1 is the worst or greatest concern) of your current physical pain/discomfort and mark it on the figures below.***

#1	
#2	
#3	
#4	



11. If you feel that you are experiencing unusual levels of stress in one or more of the following areas Please circle 'Yes" if not circle "No":

Home	Yes	No
Work/School	Yes	No
Financial	Yes	No
Relational	Yes	No

13. Please describe a typical day of activity for you.

Example*: "My morning Starts at 6:00 am and I drink a cup of coffee and drive to work. I sit at a desk until noon and order lunch from a local restaurant. I typically work through lunch. I sit at a computer and talk on the phone and end my work day at 6pm. I drive home, pick up my kids and eat dinner around 7pm. I do house chores and am in bed by 11pm."*

14. Please describe your shoe wear? What do you wear the most throughout the week?

15. Are you sleeping well?

16. What are your daily work duties/demands?

17. What physical activities and/or physical positions can you not perform without discomfort or significant tension? (I.e. kneeling down, reaching overhead)

18. What self-care strategies do you currently use to manage your own health and why? (Ice packs, stretching, acupuncture, magnets, heating pad, massage, etc.)

19. Do you play a musical instrument? If so, which instrument, how long, how many hours of practice/week?

20. What have you found to be positions of relief or things you do to manipulate your own body during the day to deal with any pain or discomfort?

18. Do you have confusion or frustrations regarding exercise and wellness strategies – conflicting advice or information you have been given or read yourself?

19. Do you feel that with each passing years you are getting healthier or unhealthier?

20. Please include any additional comments or concerns you may have (use back if needed)