

Therapist Assessment Form

The information requested on this questionnaire is important to develop your customized program. All information and results are CONFIDENTIAL.

Today's Date ___/___/___

Last Name_____ First_____ MI_____

Address_____

City_____ State_____ Zip_____

Social Security Number _____ - _____ - _____

Phone Number H (_____) _____ - _____ W (_____) _____ - _____

Physician's Name_____

Physician's Number_____

May we send your physician a summary of your results? Yes No (Circle one)

Person to Contact in an Emergency:

Name_____

Relationship_____ Phone (_____) _____ - _____

Your Date of Birth _____ / _____ / _____ Age _____ Sex M F (Circle one)
Month Date Year

What motivated you to set up an appointment?

What do you expect to accomplish while working with a Therapist?

Have you ever been treated by a Therapist? Y/N

If yes, please tell us about the treatment;

MEDICAL HISTORY

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

- | | NO | YES |
|---|--------------------------|--------------------------|
| 1) History of heart problems, recurring chest pain, heart murmur, or stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Diagnosis of Hypertension or take medicine for same | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Asthma, breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Cancer (other than skin) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Seizures, seizure medication, neurological problems or severe dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Gallbladder disease or intestinal problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Back problem, joint or muscle disorder still affecting you | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Recent surgery (last 12 months) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Hernia or any condition that may be aggravated by lifting weights | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Physician's advice not to exercise | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN ONLY:

- | | | |
|--|--------------------------|--------------------------|
| 12) Are you pregnant, lactating or anticipating becoming pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If your answer is YES to any question above, give *brief* explanation: _____

- | | | | |
|--|--------------------------|--------------------------|--------|
| 13) History of total Cholesterol greater than 200 mg/dl | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14) Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55 | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15) History of cigarette smoking | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16) Do you take vitamins? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17) Are you allergic to soy? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18) Are you allergic to lactose / dairy products? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19) Are you taking any medications?
what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | If so, |

SIGNATURE