Health History Cont.

Exercise: ___ None ____Mild ____ Moderate ___ Heavy

Exercise Frequency: ___Daily ___ >4 days/wk ___< 4days/wk ___Seldom

Work Activity: ___ Sitting ___ Standing ___ Light Labor ___ Heavy Labor

Habits: ___Smoking (Packs/Day____) ____Alcohol (Drinks/Week ___)
___Coffee/Caffeine (Cups/Day___) ___ High Stress Level/Reason____________________________

Medication:____
____
____

Allergies:____
____

Vitamins/Minerals:____
____
____

Are you pregnant? Yes / No **Due Date:** __________

Injuries/Surgeries you've had, any artificial parts (i.e. pins, wires or screws):

Description:	Date:
______________________________________	______________________
______________________________________	______________________
______________________________________	______________________
______________________________________	______________________
______________________________________	______________________

Additional Information you'd like us to know:____
____
____
____
____
____

Signature: ______________________________________ Date:______________________