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Core Restore Health History Report

PRINT CLEARLY PLEASE

Name: _____Phone: _____Cell: _____

Complete Address: _____

Email: _____

Sex: _____DOB: _____ Age ____Emergency Contact #: _____

1. Have you ever had? (Please check the ones that apply to you):

- High blood pressure_____
- Heart or circulation disorders_____
- Seizures_____
- Dizzy spells_____
- Diabetes_____
- Degeneration Joint Disease _____
- Arthritis/Osteoarthritis_____
- Scoliosis_____
- Kyphosis_____
- Osteoporosis_____
- Auto Immune Deficiency Disease_____
- Asthma_____
- Direct Injuries/Trauma to Head/Neck_____
- Joint swelling/stiffness_____
- Multiple Sclerosis_____
- Epilepsy/Seizure Disorder_____
- Cancer/Tumors_____
- Chronic Fatigue Syndrome_____
- Fibromyalgia_____
- Thyroid Condition_____
- High Cholesterol___/____
- Recent Infections_____
- Neuropathy____ Location_____
- Smoking History_____
- Back or Neck Problems_____
- Car Accidents/Whiplash_____
- Headaches_____
- Average Hours Sleep per Night_____ #of hours
- Other_____

2). Do you 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 #3		
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?		

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

_____
_____
_____
_____
_____
_____
_____
_____

4) Please identify any diagnosed diseases in the boxes below:

Diagnosed Diseases *X-Rays, MRI Reports, CT Scans reports can be provided*	**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)	

5). Do you have any METAL or SILICONE anywhere in your body: pins/plates post-fracture, pacemaker, implants, major dental work?

_____

_____

6). Have you had cosmetic/plastic surgeries? Please describe below: (include Botox)

_____

_____

7). If you have elective surgeries, within what time frame where the surgeries?

1-2yrs_____3-4yrs_____5-6yrs_____more than 7 yrs b/w each surgery____

8). Please list any current medications, self prescribed medication, or dietary supplements that you are taking:

_____

_____

_____

_____

9). Do you wear orthotics or a mouth guard at night?

_____

10). Do you wear heels or flip-flops? Yes or No. Describe typical footwear:

_____

11). Do you use a foam roller in your workout routine? Yes or No?

12). (Women) If you still menstruate or you are currently menstruating or close to having your period? Yes or No

13). Have you had steroid or cortisone shots? How many different shots, how many years ago and where did you have the shots in your body?

_____

_____

14). Do you have any abnormal trouble with vision? Yes or No / Hearing? Yes or No

Please complete the following information as completely and thoroughly as possible. *No check marks, explain the issue(s).*
This is an extremely important section of this questionnaire.

15). Trauma/Injury/Surgery History (Every significant physical pain you have experienced) includes even what you might consider minor, non-medically treated injuries.

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					
Lumbar/ Low back					
Abdominals/					

Ribs Hernia					
Pelvis/Hips Femur/Thigh					
Shoulder/ Scapulae/ Rotator cuff					
Elbow i.e. tennis elbow					
Arm					
Wrist/Hand Fingers *Carpal Tunnel*					
Body Part	1 -18 years	19 - 29 years	30 – 45 years	46 - 60 years	60 + years
Knees Patella, ACL, Tendonitis					
Ankles/Feet					

16). What is your occupation?
Physical - Sitting, Standing, Positional How Long/Day? 7-8 hours
Emotional - Hi Pressure, Boring, Intermittently Hi & Lo Pressure
Stressful- How long under this stress? In years_____
What are your daily demands at your occupation?

17). What type of self care do you do? C for Current and P for Past

- Massage _____
- Acupuncture _____
- Rolfing _____
- Chiropractic _____
- Yoga _____
- Heating Pads_____
- Stretching_____
- Active Release Technique _____
- Reiki _____
- Cranio-Sacral _____
- Physical Therapy _____
- Pilates _____
- Ice_____
- Magnets_____

18). **Please prioritize the severity (#1 is the worst or greatest concern) of your current physical pain/discomfort.**

#1	
#2	
#3	
#4	

19). Exercise History: ***(Past within the last 2 years)***

	Cardio Equipment ***(List the type of Machines)***	Times per week	How Long?	Intensity: Subjective Scale (1-10)	Current or Past
Walking					
Running					
Biking					
Swimming					
Cardio Equipment	A. B. C.				
Strength Training				Sets: Reps:	
Crossfit/Power Training					
Resistance/Endurance Training					
Stretching (circle) **YES or NO**	**Passive or Active**				
Other:					

20). 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

21). Nutritional Status

Type of Diet	
Food Allergies	
Are you a conscious eater?	
Do you eat out more than you eat at home?	
How many times do you eat a day?	
What are the times you eat?	

22). Are you sleeping well? _____

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

#1	
#2	
#3	
#4	
#5	

24). 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?

_____
_____
_____

25). Please list and rate the goals for your movement/exercise program as far as how close or far you are from reaching them right now; Circle a number for each goal listed.

YOUR GOALS	Far				Half	Way				Done
	1	2	3	4	5	6	7	8	9	10
	1	2	3	4	5	6	7	8	9	10
	1	2	3	4	5	6	7	8	9	10
	1	2	3	4	5	6	7	8	9	10
	1	2	3	4	5	6	7	8	9	10