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Core Restore Training System Health History Form

Name: _____ Gender:_____ Birthdate:_____ Age:____

Mailing Address: _____

Physical Address: _____

Email: _____

Phone #:_____ Emergency Contact #: _____

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

- High blood pressure ☐
- Low blood pressure ☐
- Heart or circulation disorders ☐
- Seizures ☐
- Dizzy spells ☐
- Diabetes ☐
- Degeneration Joint Disease ☐
- Arthritis/Osteoarthritis ☐
- Scoliosis ☐
- Kyphosis ☐
- Osteoporosis ☐
- Auto Immune Deficiency Disease ☐
- Joint swelling/stiffness ☐
- Asthma ☐
- Direct Injuries/Trauma to Head/Neck ☐
- 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 ☐
- # of Hours Slept per Night_____
- Other_____

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

_____
_____
_____

3. Be very specific about your injury, surgery, and accident history.

_____
_____
_____
_____
_____
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