CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

CONTACT: kids@ovcrossfit.com Phone: 740-296-9700

Clients, please include as much detail as possible. Once you have filled in the form, please return it to the email address above or return the form to OV CrossFit.

Name：_____

Email Address: _____

Phone Number: _____

Age: _____

Height: _____

Date and Place of Birth: _____

Relationship Status: _____

Current Weight: _____

Weight Six Months Ago:

One Year Ago: _____

Would you like your weight to be different? YES / NO

If so, how? _____

_____

_____

_____

_____

Children? YES / NO

Pets? YES / NO

Occupation: _____

Hours of Work Per Week _____

What is Your Ancestry? _____

Blood Type (if known): _____

Please list your main health concerns: _____

_____

_____

_____

_____

_____

Any other concerns and/or goals? _____

_____

_____

_____

_____

_____

At what point in your life did you feel best? _____

_____

_____

_____

_____

_____

The most important thing I should do to improve my health is: _____

_____

_____

_____

_____

_____

Do you sleep well? _____

How many hours? _____

Do you wake up at night? YES / NO

If so, why? _____

_____

_____

How do you feel when you wake up? _____

Do you experience discomfort (pain, gas, bloating, heartburn) after eating? YES / NO

Please explain: _____

_____

_____

_____

On a scale from 1-10, how much stress do you have in your life right now? _____

_____

How is your energy level throughout the day? _____

Do you tend to get sleepy at any point or is your energy steady throughout the day?

Do you have any digestive issues? YES / NO

Please explain: _____

Number of bowel movements per day: _____

Do you ever experience constipation or diarrhea? YES / NO

If yes, please explain: _____

Any known food allergies or sensitivities? Please list: _____

FOR WOMEN ONLY

Age of your first period: _____

How many days in your flow? _____

Do you experience PMS? _____

Birth control history: _____

Yeast infections or UTI's? _____

Are your periods regular? YES / NO

How frequent? _____

_____

If yes, please describe symptoms: _____

_____

_____

MEDICAL HISTORY & CURRENT CARE

Please list any surgeries, accidents, injuries, hospitalizations, or childhood diseases you have had along with the type and the date: _____

_____

_____

_____

_____

Are you currently under a practitioner's care for a specific health issue? YES / NO

If so, what treatments are you receiving? _____

_____

_____

_____

Please list any vitamins/minerals/herbs/homeopathic remedies, prescription/non-prescription medications, diet pills, or any other supplements? _____

What foods did you eat often as a child? _____

What's your food like these days? _____

How many meals do you eat in a day? _____

Describe a typical breakfast/lunch/dinner: _____

Do you drink alcoholic drinks? YES / NO

Do you drink caffeinated drinks? YES / NO

Typical liquids consumed in a day:_____

Do you crave sugar, salt, coffee, cigarettes, alcohol, or have any major addictions? YES / NO

If yes, please explain: _____

_____

_____

_____

FAMILY HEALTH HISTORY

How is your mother's health? _____

How is your father's health? _____

Have you tried addressing your current health concerns in the past? YES / NO

Do you feel ready to make the changes necessary to achieve your health goals? YES / NO

Anything else you want to share? _____

_____

_____

_____

_____