Dakotah! SPORT AND FITNESS

Health History Questionnaire

Date: _____ **Location:** _____

Please complete this questionnaire as accurately as you can. The information you provide will be used as a basis for dietary advice. The answers you provide will be kept confidential.

(Use black or blue pen only.)

Personal Data

Name _____ Home Phone _____

Address _____ Cell Phone/Pager _____

City _____ Zip Code _____

Occupation _____ Employer Phone _____

Birthdate _____ _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Other

Children living at home: ❑ Yes ❑ No If yes, how many?

Physician _____ Physician's Phone _____

Address of Clinic _____

Medical History

Please check if you are *currently* being treated for any of the following medical conditions:

Heart Disease/Heart Attack ……	☐	Gout ……	☐
Angina (chest pain) ……	☐	Hypoglycemia ……	☐
Cardiac Arrhythmia ……	☐	Chronic Renal Failure ……	☐
Stroke ……	☐	Dialysis ……	☐
High Blood Pressure (140/90 +) ……	☐	Transplant ……	☐
High Cholesterol (200 mg/dl +) ……	☐	Kidney Stones ……	☐
High Triglycerides (200 mg/dl +) ……	☐	Thyroid condition: ……	☐
Cancer (on radiation/chemo) ……	☐	Hormone Excess ……	☐
Diabetes (diet controlled) ……	☐	Hormone Deficiency ……	☐
Diabetes (oral medication) ……	☐	Liver Disease ……	☐
Diabetes (insulin controlled) ……	☐	Seizures ……	☐
If "yes" to above, how many injections per day? ……		Prescription for MAOI Medications ……	☐
Intestinal Bypass/Stomach Stapling ……	☐	Prescription for SSRI Medications ……	☐
History of Gall Bladder Disease or Gall Stones ……	☐	Major Surgery in the past 3 months ……	☐
Gall Bladder Removed ……	☐	Anorexia/Bulimia ……	☐
Ulcer ……	☐	Binge Eating Disorder ……	☐
Diverticulitis ……	☐	Depression ……	☐
Crohn's Disease ……	☐	Osteoporosis ……	☐
Ulcerative Colitis ……	☐	Indigestion ……	☐
Esophageal Reflux ……	☐	Loss of Appetite ……	☐
Chewing or swallowing difficulties ……	☐	Prescription for diuretic medication……	☐

Are you currently being treated for a condition not listed? ❑ Yes ❑ No

If yes, please specify: _____

Has your physician prescribed medications/supplements for you? ❑ Yes ❑ No

If yes, please specify:_____

Are you taking any over-the-counter supplements? ❑ Yes ❑ No

If yes, please specify:_____

Has your physician restricted you from exercise, such as walking? ❑ Yes ❑ No

If yes, please specify:_____

Client Review/Signature

I acknowledge and fully agree that the responses to the Health History Questionnaire are complete and correct and will be used to design a nutrition therapy program/menu plan.

I also hereby release Dakotah! Sport & Fitness, its affiliates, directors, officers, and employees, from any and all liabilities, damages, and causes of action which may or could result from the information I have provided on the Health History Questionnaire.

_____ _____

Client Signature Date