Functional Integration Health History

Name____Date______________

Address________________________________City, State, Zip___________________________

Cell__________________Hm/Wk_________________Email______________________________

Birthdate_____________Sex_________Sport(s)________________Blood Type______________

Height_____________Current Weight______________Dominant Hand______________________

Are you currently under a physicians care?____________If yes, please explain________________
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All Medications/Supplements____
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Allergies____
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Any Injuries, Surgeries or Accidents w/Dates______________________________________
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Describe Specific Chronic Conditions____
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Describe your weekly training habits specifically________________________________
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Sport/Training Program: ______________________________Intensity Level 1-5: ______________

How many times per week: ____________________________For how long: __________________

Daily Sleep Pattern

How many hours per night: __________hrs   How many hours do you need: __________hrs

What position(s) do you sleep in: ____

How old is your bed: _______months/years   How old is your pillow: ________months/years

Do you sleep through the night, specifically describe: _______________________________________

Stress Levels

On a scale of 1-10, 10 being the highest rate your stress levels in each area:

Home: __________   Work: __________   School: __________   Relationship: __________

Family: __________   Other: ____

Do you meditate: yes/no   How often: __________times per day/per week

Do you see a mental health therapist: yes/no   How often: _______________________

If yes, who is the provider: ____

Do you smoke: yes/no   cigars/cigarettes/marijuana   chewing tobacco: yes/no

How often: ______________times per day/week/month

* FEMALES ONLY: What year did your menstrual cycle begin: __________ Are you regular: yes/no

Current Health/Performance Goals: ____

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Please Circle All Conditions That Apply Currently or Previously:

Heart Disease	Stroke	Anxiety
Cancer	Asthma	Ulcers
Lung Disease	Gastrointestinal Disease	Diabetes
Depression	Arthritis	Food Allergies
Kidney/Liver Disease	Neuromuscular Disease	Gallbladder Disease
Low Back Pain	Psychological Problems	Anorexia
Bulimia	Compulsive Overeating	Kidney Stones
High Blood Pressure	Joint Problems	Chest Pain
Hypoglycemic	Hypo/Hyper Thyroid	Cysts
Emphysema	Tuberculosis	Smoking
High/Low Cholesterol	Learning Disabilities	Pregnancy

Other:____

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