



HISTORY

BODY IN BALANCE PERFORMANCE ENHANCEMENT CENTER

Name: _____

DOB: _____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following:

- Heart disease: (specify): _____
- High cholesterol
- High Blood Pressure
- Asthma/Lung disease
- Diabetes
- Thyroid problem
- Cancer: (specify): _____
- Kidney Disease
- Osteoporosis
- Other

Do you have any problems with your:

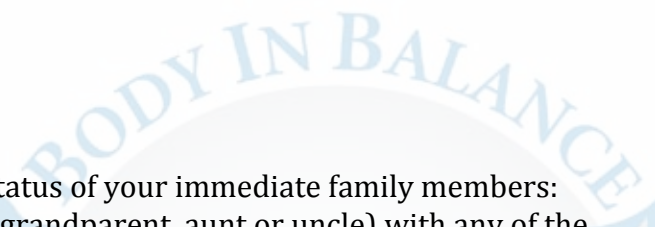
- Back
- Shoulders
- Hips
- Neck
- Elbows
- Knees
- Wrists
- Ankles

If yes, please explain _____

SURGICAL HISTORY: Please list all prior operations (with dates):

611 Old Willets Path, Suite 105
Hauppauge, NY 11788
p:(631) 232-5350 f:(631) 232-1583

12 Technology Drive, Unit 12-2
East Setauket, NY 11733
p:(631) 444-5041 f:(631) 444-5043



FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Diabetes_____	High cholesterol_____
Cancer, specify type_____	High blood pressure_____
Heart disease_____	Stroke_____
Depression/suicide_____	Bleeding or clotting disorder_____
Genetic disorders_____	Asthma/COPD_____

SOCIAL HISTORY

Tobacco Use

Do you smoke cigarettes: Never Quit, date_____

Current Smoker: _____ packs/day _____ # of yrs

Other Tobacco (specify):_____

Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes _____ # drinks/week

Is your alcohol use a concern for you or others?_____

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OTHER CONCERNS

Weight: Are you satisfied with your weight?

No Yes

Diet: How do you rate your diet?

Good Fair Poor

Exercise: Do you exercise regularly?

No Yes

What kind of exercise? _____

How long (minutes) & How often? _____

EMERGENCY CONTACT

Name: _____ Phone Number: _____

PHYSICIAN

Name: _____ Phone Number: _____

Current Medications: _____

Signature: _____ Date: _____

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