Fax 204-691-3964 or email espdietitianccs@yahoo.com

HEALTH HISTORY FORM

(For client to complete) **Today's Date:** _______________

GENERAL INFORMATION:

Name: ____________________________________ Birth date: ___________________ Age:___
month / day /year

Address:____
Apt # Street City postal code

Telephone (home):__________________________ (work):______________________

Occupation: _______________________________ Employer: ___________________

Family Physician: ____

Address:____
Suite # Street City postal code

Telephone: ______________________________

Private Insurance Company: ____

Contract __________________________________ Group/Policy# ________________

Plan #____________________________________ ID# ________________________

*Credit card# ________________________________Expiry date:____________ VIN_____
*Note: Will be charged if insurance doesn't cover services used.

MEDICAL HISTORY:

Height: _____"______cm Weight ____lb ______kg BMI _____

Waist Circumference _____"______cm

Date of last physical examination? ____

Are you presently under the care of a specialist/physician? ☐ Yes ☐ No
If so, MD name and phone number ____

Are you presently taking any pills, drugs or medications?

Brand name	Drug name	Dosage	AM	Lunch	PM

ESP DIETITIAN

Counselling & Consulting

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Are you taking any vitamin / mineral / herbal supplements? ☐ Yes ☐ No

If yes, what?____

Do you use any other health services? ☐ Yes ☐ No

If yes, what? ____

Family Medical History: ____

Do you have, or have you had, any of the following? (check all that apply)

☐ Heart disorder ☐ High blood cholesterol ☐ High triglycerides ☐ High blood pressure

☐ Low blood pressure ☐ Diabetes ☐ High blood sugars ☐ Low blood sugars

☐ Fainting spells ☐ Hepatitis/jaundice ☐ Tuberculosis ☐ Asthma

☐ Cancer ☐ Thyroid problems ☐ Psychiatric care ☐ Stroke

☐ Other (please specify) ____

Surgery (if so, what type and when?) ____

Allergy to medication (if so, what?) ____

____

PHYSICAL ACTIVITY HISTORY:

What type of activity do you do?____

Duration of Activity? Please check appropriate box

☐ 5-10 minutes ☐ 15 minutes ☐ 15-30 minutes ☐ 30-45 minutes ☐ ≥60 minutes

How many times a week are you active?

☐ once/week ☐ 2x/week ☐ 3x/week ☐ 4-5x/week ☐ 6x/week ☐ 7x/week

Total of exercise /week? _____ minutes x ____ times /week = ____________________

Estimated exertion? ☐ normal breathing ☐ increased breathing ☐ heavy breathing