

Health and Social History Form

Name _____ Date of Birth _____

SOCIAL HISTORY

Please Circle Correct Answers

Family/Work/School

Marital Status: Single Married Widowed Divorced In a Committed Relationship

Significant Others Name _____

Current Work Status: Full Time Part Time Unemployed Retired Self Employed

Current Occupation: _____ Is it a Sedentary, Mildly Active or Active Position? Please Circle One

Current School Status: Full Time Part Time Current School You are Attending _____

List Your Current Household Members _____

Do You Currently Exercise? Yes No Occasionally If Yes how many times a week? _____

If Yes what type of exercise do you perform? _____

What type of Daily Diet do you Currently Have? Poorly Balanced Well Balanced Vegetarian Vegan

Low Carb/Low Fat Low Calorie Multi Vitamin Iron Therapeutic/List What Type? _____

Please Answer The Next Safety Questions

Seat Belt Use: Never Sometimes Always

Guns In Home: Yes No Sometimes If Yes or Sometimes is Gun Kept Locked in Cabinet: Yes No

Drug/Alcohol/Tobacco/Caffeine

Alcohol Use: None Occasional Moderate Recently Quit Would Like Help Quitting

Type of Alcohol: Beer Wine Hard Alcohol How Many Drinks Per Night/Week? _____

Tobacco Use: Never Current Everyday Smoker Former Smoker Occasional Smoker

Number of Cigarettes Smoked Daily? _____ Years Smoking? _____ Years Since Quitting? _____



Patient Name _____ Date of Birth _____

Patient ID _____ Date of Service _____

Social History

Marital Status

Work/ School Status

Current Exercise Regiment

<p>Single <input type="checkbox"/></p> <p>Married <input type="checkbox"/></p> <p>Widowed <input type="checkbox"/></p> <p>Divorced <input type="checkbox"/></p> <p>Committed <input type="checkbox"/></p> <p>Significant Other's Name _____</p>	<p>Full Time <input type="checkbox"/></p> <p>Part Time <input type="checkbox"/></p> <p>Retired <input type="checkbox"/></p> <p>Self <input type="checkbox"/></p> <p>Student <input type="checkbox"/> Full <input type="checkbox"/> Part</p> <p>Current Occupation _____</p>	<p>Exercise History Details</p> <p>Inactive <input type="checkbox"/></p> <p>Light <input type="checkbox"/></p> <p>Moderate <input type="checkbox"/></p> <p>Heavy <input type="checkbox"/></p> <p>Vigorous <input type="checkbox"/></p> <p>Times Per Week</p> <p>None <input type="checkbox"/></p> <p>1 X Week <input type="checkbox"/></p> <p>2 X Week <input type="checkbox"/></p> <p>3 X Week <input type="checkbox"/></p> <p>4 X Week <input type="checkbox"/></p> <p>5 X Week <input type="checkbox"/></p> <p>6 X Week <input type="checkbox"/></p> <p>Daily <input type="checkbox"/></p>	<p>Type of Exercise Check All That Apply</p> <p>Walking <input type="checkbox"/></p> <p>Jogging <input type="checkbox"/></p> <p>Running <input type="checkbox"/></p> <p>Cycling <input type="checkbox"/></p> <p>Weight Training <input type="checkbox"/></p> <p>Team Sports <input type="checkbox"/></p> <p>Racquet Sports <input type="checkbox"/></p> <p>Aerobic Classes <input type="checkbox"/></p> <p>Exercise Classes <input type="checkbox"/></p> <p>Yoga <input type="checkbox"/></p> <p>Martial Arts <input type="checkbox"/></p> <p>Stretching <input type="checkbox"/></p> <p>Golf (walks) <input type="checkbox"/></p> <p>Bowling <input type="checkbox"/></p> <p>Housework <input type="checkbox"/></p> <p>Gardening <input type="checkbox"/></p> <p>Yardwork <input type="checkbox"/></p> <p>Other _____</p>
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