A.X.O.N
Health Questionnaire

All documentation is kept confidential and will not be disclosed without your written consent.

Name:_____ Date:_____

Address: _____

Phone Number: (H): _____ (W): _____ (C): _____

Email: _____

Date of Birth: _____ Age: _____

Goals hope to achieve from AXON Program: _____

_____

Personal Health History – Please check off any that may apply:

Allergies	☐	Heart Disease	☐
Alzheimer's Disease	☐	Heart Palpitations	☐
Anxiety	☐	Hypertension (High Blood Pressure)	☐
Asthma	☐	Hypotension (Low Blood Pressure)	☐
Arthritis:			
Rheumatoid	☐	Joint Replacement	
Osteoarthritis	☐	Specify: _____	☐
Blood Clots	☐	Migraines	☐
Bursitis	☐	Multiple Sclerosis	☐
Cancer	☐	Osteoporosis	☐
Type:_____			
Cholesterol (high)	☐	Parkinson's	☐
Chronic Cough	☐	Scoliosis	☐
Depression	☐	Shortness of Breath	☐
Diabetes	☐	Smoke	☐
		_____ per day	
Dizziness/Fainting	☐	Stress	☐
Emphysema	☐	Stroke	☐
Fibromyalgia	☐	Date:_____ Affected side: _____	
Fractures	☐	Tendonitis	☐
Location:_____			
Headaches	☐	Thyroid Dysfunction	☐
Heart Condition	☐	Other: _____	☐
Specify: _____		_____	

Please list any surgeries you have had in the past, including dates:_____

_____

Current Medications: _____

_____

_____

Additional Health Information: _____

_____

Physical Fitness, Physical Activity/Exercise History

Have you exercised in the past? Briefly explain: _____

_____

Signature: _____ Date: _____
