Fitness by Dot

Get Out of Pain Health Assessment

First name

Last name

Date

Email address

Phone number

Address

Known diagnosis related to your back, if any

Generally, how frequently are you in pain on a scale of 1 - 5 ?

1 - Constant Pain

2 - Pain every day

3 - On and off

4 - Now and then

5 - No pain

On a scale of 1 - 10, how much pain are you in on average, when 1 = low and 10 = high?

1 2 3 4 5 6

7 8 9 10

Indicate what part of your back is problematic, if known. Include which vertebrae if known (e.g. cervical, thoracic, lumbar, sacral, C-6, L-5/S-1, L-4/L-5, etc.)

What if anything has been helpful for your back pain? (e.g. stretching, yoga, exercise, pain medication, anti-inflammatories, muscle relaxants, other)

Do you consider yourself:

Underweight   Overweight   About right

Do you exercise?

yes, a lot   yes   sometimes   rarely   no

If yes, type/types of exercise, # of times per week/month, and duration

Do you smoke?

yes   no

If yes, what (cigarettes, pipe, pot), #/day or week

Do you drink:

Alcohol   Coffee   Tea   Soft drinks   Water

Specifics and amount per day/week

Are you dieting?

yes   on and off   no

What are your eating habits?

Do you have any known food allergies?

Indicate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest)

1   2   3   4   5   6   7

8   9   10

List any current health problems for which you are being treated.

Please indicate if you have or have had any of the following:

	Past	Present	Both	Not Applicable
Alcoholism / Drug Addiction				
Allergies				
Arthritis				
Asthma				
Bursitis				
Carpal Tunnel				
Diabetes				
Eating Disorder				
Environmental Sensitivities				
Epilepsy				
Fatigue				
Fibromyalgia				
Health Condition				
Hernia				
High Blood Pressure				
Low Blood Pressure				
Joint Pain				
Migraine				
Nervous Tension				
Osteoporosis				
Sciatica				
Shortness of Breath				
Sinus				
Tight Shoulders				

Please indicate if you have or have had any of the following:

	Past	Present	Both	Not Applicable
Ulcers				
Autoimmune Issues, Please Specify				

Autoimmune issues:

Are you taking supplements? Please specify:

What are your biggest challenges when it comes to your back pain?

What have you tried to do to resolve your back pain? Did it work?

What is not resolving your back pain costing you?

How much longer are you willing to deal with your back pain?

What do you want instead for your back? What is your vision of how it could be?

What would your life be like if your back didn't hurt?

How committed are you on a scale of 1 to 10 to getting rid of your back pain?

1 - not	2	3	4	5
6	7	8	9	10 - totally!

Additional information

Please fill out this assessment, save it using your name in the title and email to: **fitnessbydot@earthlink.net**