

EXERCISE & HEALTH HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

ADDRESS: _____

DAYTIME PHONE: _____ EVENING PHONE: _____

AGE: _____ BIRTH DATE: _____ GENDER: MALE FEMALE

1. Are you presently involved in physical activity for exercise? YES NO

(a) If yes, how long have you been active and what kind of activity are you involved in?

(b) If no, have you ever been involved in physical activity for exercise and what kind?

2. On a scale of 1 to 10 (1 being the lowest and 10 being the highest), rate yourself in the following areas:

Your present athletic ability _____
Your present cardiovascular capacity _____
Your present muscular capacity _____
Your present flexibility capacity _____

3. What goal(s) would you like to work toward over the next few months?

Lose Fat Increase Energy Improve Eating Habits
 Tone Up Strengthen Heart Become Stronger
 Exercise More Reduce Stress Body Fat/Weight Loss

Other: _____

4. How much time are you willing/able to devote to an exercise program?

Minutes per day _____
Days per week _____

5. Have you ever been injured or do you experience pain in any of the following areas? If yes, please describe the injury and date it occurred.

Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Shoulders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arms/Hands	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Back	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Legs/Feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

6. Have you ever had any surgeries? If yes, please explain in detail.

7. Do you have or have ever had any of the following conditions? If yes, please describe.

Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eye Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

8. Are you currently taking any medication? If yes, what kind and for what condition?

9. (a) Are you pregnant or have been pregnant within the last three months? Yes No

(b) Have you experienced menopause or having symptoms of menopause? Yes No

10. Do you smoke? Yes No If yes, how much? _____

11. How would you rate your daily stress level?

Low Moderate High

12. Briefly describe your resting and sleeping habits on an average day.

13. What other health care professionals do you see or have you seen?

- | | |
|--|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Massage Therapist |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Dietitian/Nutritionist |
| <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Other: _____ |

14. Do you think a personal trainer can help you? Yes No If yes, what role would you like your personal trainer to play in your fitness program?

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Educator | <input type="checkbox"/> Motivator |
| <input type="checkbox"/> Coach | <input type="checkbox"/> Advisor |
| <input type="checkbox"/> Supporter | <input type="checkbox"/> Other: _____ |

15. On what days and times would you be interested in meeting with your personal trainer?

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Monday | |
| <input type="checkbox"/> Tuesday | |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Thursday | <input type="checkbox"/> Afternoon |
| <input type="checkbox"/> Friday | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Saturday | |
| <input type="checkbox"/> Sunday | |

16. Is there any other information not requested here, that you feel we should know about?

The information I have given on this form is, to the best of my knowledge, complete and accurate.

Signature: _____
Printed Name: _____
Date: _____