**Health History Questionnaire**

**General Information**

|  |  |
| --- | --- |
| Name |  |
| Birthday |  |
| Gender |  |
| Address |  |
| City/State/Zip |  |
| Home number |  |
| Cell number |  |
| Email |  |
| Employer |  |
| Occupation |  |
| Emergency contact |  |
| Relationship |  |
| Home number |  |
| Cell number |  |

**Medical Information**

|  |  |
| --- | --- |
| Are you under the care of a physician, chiropractor, or other health care professional for any reason? |  |
| Are you aware of any disease or disorder that would complicate your participation in a testing or exercise program? |  |
| Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise? |  |
| Are you taking any medications? If yes please indicate the type of medication, dosage, frequency and reason(s) for taking it. |  |
| Do you smoke? |  |
| Please list any allergies. |  |
| Recent surgeries? |  |
| Other medical problems/considerations, recent illness(es), hospitalizations(s), or injury. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Condition** | **Never** | **Now** | **Have Had (Date)** |
| Heart murmur, clicks, or other cardiac findings |  |  |  |
| Frequent extra, skipped, or rapid heart beats/palpitations |  |  |  |
| Heart attack, coronary bypass, or other cardiac surgery |  |  |  |
| Chest pain/angina (especially upon exertion |  |  |  |
| Currently pregnant |  |  |  |
| Diagnosed with high blood pressure |  |  |  |
| Leg cramps during exercise |  |  |  |
| Chronic swollen ankles |  |  |  |
| Varicose veins |  |  |  |
| Frequent dizziness/fainting |  |  |  |
| Blood clot |  |  |  |
| Severe arthritis |  |  |  |
| Orthopedic problem(s) or complaint(s) |  |  |  |
| Chronic back pain |  |  |  |
| Musculoskeletal problems(s) or complaint(s) |  |  |  |
| Asthma |  |  |  |
| Cancer |  |  |  |
| Diabetes |  |  |  |
| Epilepsy |  |  |  |
| Rheumatic Fever |  |  |  |
| Scarlet Fever |  |  |  |
| Bronchitis |  |  |  |
| Stroke |  |  |  |
| Pneumonia |  |  |  |

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Health History**

Please indicate the number of blood relatives (mother, father, grandparents, brothers/sisters, children) who:

|  |  |
| --- | --- |
| have had a heart attack prior to age 65 |  |
| have had a stroke |  |
| have had or now have diabetes |  |
| have been or are substantially overweight |  |

**Personal Training Goals**

What would you like to get out of personal training?

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How many times are you interested in coming per week (45 minute sessions)?

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What kind of exercise do you enjoy?

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