Health History

Name: _____ Date of Birth: _____ Weight: _____ Height: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

In order to design a safe and effective fitness program it is important that you complete the following Health History. It is crucial that you answer **all** the questions honestly and to the best of your ability. *Please be advised that all information is kept strictly confidential.* . I strongly recommend that upon beginning an exercise routine that you consult your doctor.

A. Check the appropriate response. Read all questions thoroughly:

Has your doctor ever told you that you have heart problems? _____ Have you ever had pain in your chest? _____

Has your doctor ever told you that you have high blood pressure? _____ Have you ever had a stroke or heart attack? _____

Do you ever feel faint or have dizzy spells? _____ Have you had surgery in the last six months? _____

B. Check the appropriate conditions:

Diabetes____ Epilepsy____ Blood Pressure____ Asthma____ Arthritis____ Heart ____ High Cholesterol____ Pregnancy____

C. Have you injured or have pain in the following areas? Check the appropriate lines.

Neck ____ Upper Back ____ Shoulders ____ Knees ____ Hips ____ Lower Back ____ Elbows ____ Wrists ____

If yes, please explain: _____

D. Are you currently taking any medications? Yes ____ No ____

If you checked "Yes," please list medications, dosage, and for what condition:

Medication: _____ Dosage: _____ Condition: _____

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E. Are you currently undergoing treatment from any of the following? Physiotherapist ___ Chiropractor ____ Massage Therapist ___

If yes, why? _____

F. What is your current exercise level? None____ 2–3 times per week____ 4–5 times per week____ What type?_____

G. How would you rate your level of stress on a daily basis? Low _____ Moderate _____ High _____

H. What to you think your ideal weight should be? (optional) _____

I. Have you ever been your ideal weight? (optional) yes____ no _____ If yes, how long ago? _____

J. Are you currently following any type of special diet? Please check appropriate line:

Reduced Calorie____ Increased Calorie____ Low Fat____ Low Cholesterol____ Low Salt____ Other_____

K. What are your exercise goals? Number the following exercise benefits according to their importance to you (1 being the most important): Weight Loss____ Weight Gain____ Stress Reduction____ Increased Strength____ Posture____ Other_____

L. Estimate how many hours of sleep you get each night: _____

M. Are there any other reasons (health or personal) that may limit or prevent you from exercising?

_____

_____

(*Please be advised that certain health restrictions may require you to obtain medical clearance from your physician before training*)