



**Personal Training:
PERSONAL/HEALTH HISTORY FORM**

Personal Information:

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Age _____ Sex ___M___F Race _____

Occupation _____ Highest education completed _____

Physician's Name _____ Phone _____

Person to contact in case of Emergency:

Name _____ Relationship _____ Phone _____

For most people, physical activity should not pose any problem or hazard. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check the "Yes" or "No" opposite the question if it applies to you.

Health History:

Yes No

- _____ _____ Does your doctor know you are participating in this exercise program?
- _____ _____ Do you have history of heart problems, chest pain, murmur, flutter or stroke?
- _____ _____ Do you have increased blood pressure?
- _____ _____ Do you often feel faint or have spells of dizziness?
- _____ _____ Do you suffer from swelling in a particular area? Where? _____
- _____ _____ Have you experienced severe leg pain during walking?
- _____ _____ Do you have any chronic illness or condition?
- _____ _____ Difficulty with physical activity or advice from doctor to not exercise?
- _____ _____ Do you have bone or joint problems, such as arthritis, that has been aggravated or made worse by exercise?
- _____ _____ Have you had recent surgery (last 12 months)?
- _____ _____ Are you pregnant?
- _____ _____ Are you over age 65 and/or NOT accustomed to vigorous exercise?
- _____ _____ Are you or have you been a diabetic?
- _____ _____ Have you been hospitalized in the last two years? If so, when and why?
- _____ _____ Have you ever seen a chiropractor, acupuncturist, or other alternative medicine practitioner? If so, when and why? _____

If "YES" to any of the above questions please explain when experienced and any treatment used:

YES NO

- ____ ____ Have you experienced limping?
- ____ ____ Do you have high blood pressure? If so, what is your blood pressure without medication?
_____ mmHG
- ____ ____ Are you taking medication for hypertension? If so, what? _____
- ____ ____ Is your total serum cholesterol over 200? What is it _____
- ____ ____ Do you smoke? If not currently, when did you quit? _____
- ____ ____ How often do you have an alcoholic drink? _____
- ____ ____ Do you have diabetes? Circle: Type I or Type II When diagnosed? _____
- ____ ____ Do you have headaches? If so, how often? _____

Do you have pain or discomfort in your:

- ____ ____ Back Where? _____ How often? _____
- ____ ____ Neck Where? _____ How often? _____
- ____ ____ Arms Where? _____ How often? _____
- ____ ____ Legs Where? _____ How often? _____
- ____ ____ Have you ever torn ligaments or cartilage anywhere? Where? _____
- ____ ____ Have you ever dislocated any joints? Where? _____
- ____ ____ Have you ever had a neck injury, like whiplash? Where? _____
- ____ ____ Have you ever had back surgery or injury? Where? _____
- ____ ____ Do you ever experience tingling or numbness anywhere? Where? _____

If you checked "YES" above, please describe your pain. On a scale of 1 to 10, with 1 being almost nonexistent and 10 being excruciating, how severe is it? Does it get more or less severe as the day goes on? When do you notice it? What really aggravates it? _____

Please write a "P" for Personal and "F" for Family beside the following conditions:

- _____ Coronary heart disease, heart attack, coronary artery or heart surgery
- _____ Angina
- _____ High blood pressure
- _____ Peripheral vascular disease
- _____ Phlebitis or emboli
- _____ Other Heart problems (specify: _____)
- _____ Lung Cancer
- _____ Breast Cancer
- _____ Prostrate Cancer
- _____ Colorectal cancer (bowel cancer)
- _____ Skin cancer
- _____ Other cancer (specify: _____)
- _____ Stroke
- _____ Chronic obstructive pulmonary disease (emphysema)
- _____ Pneumonia
- _____ Asthma
- _____ Bronchitis
- _____ Diabetes
- _____ Thyroid problems
- _____ Kidney disease
- _____ Liver disease (cirrhosis of the liver)
- _____ Hepatitis
- _____ Gallstones/gallbladder disease
- _____ Osteoporosis
- _____ Arthritis
- _____ Gout
- _____ Anemia (low iron)
- _____ Stomach/duodenal ulcer
- _____ Catartacts, Glaucoma, etc.
- _____ Hearing loss
- _____ Depression
- _____ High anxiety or phobias
- _____ Substance abuse problems
- _____ Eating disorders (specify: _____)
- _____ Menstruation or menopause problems
- _____ Sleeping problems (specify: _____)
- _____ Allergies (specify: _____)
- _____ Any other health problems (please specify, and include information on any recent illnesses, hospitalizations, or surgical procedures) _____

Please check any of the following medications you currently take regularly. Also name the medication.

Heart medicine :

Blood pressure medicine:

Blood cholesterol medicine:

Hormones:

Birth control:

Medicine for breathing/lungs:

Insulin:

Diabetes medication:

Arthritis medication:

Medicine for depression:

Medicine for anxiety:

Medicine for ulcers:

Painkiller medicine:

Allergy medicine:

Thyroid medicine:

Other:

I, _____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that this information is being provided as part of my initial consultation and may be periodically updated.

I, _____, assume the risk for any changes in my medical condition that might affect my ability to exercise.

SIGNATURE _____ PRINT _____ DATE _____

If you answered "YES" to one or more questions and you have not recently done so, consult with your doctor before beginning an exercise program. Tell your doctor which questions you answered "YES" to and explain that you plan to undergo an exercise program that may include, but not limited to, weight and/or resistance training. After medical evaluation, ask your doctor

1. which activities you may safely participate in and
2. what specific restrictions, if any, should apply to your condition and which activities and/or exercise you should avoid.

I, _____, acknowledge that I have read the foregoing statements and understand the content thereof.

SIGNATURE _____ DATE _____



**Personal Training:
LIFESTYLE QUESTIONNAIRE**

Name _____ Date _____

PHYSICAL ACTIVITY

1. In the past year, how often have you been engaged in physical activity?
___ Regularly (3 to 4 times/week)
___ Semiregular (1 to 2 times/week)
___ Sporadic (1 to 2 times/month)
___ None
2. What types of physical activity do you consider “fun”? _____
3. What are your barriers for exercising? _____
4. What physical activity have you been successful with in the past (liked and participated regularly)?

5. How do you think your weight affects your daily activities? _____

SUPPORT

6. Do you feel any family, friends or co-workers have negative feelings toward your efforts at physical activity? _____
7. Is your significant other or a close friend involved in any regular activity? _____

OCCUPATION/LEISURE

8. What is your present occupation? _____
9. Does your occupation require much activity (ie. walking, getting up and down, carrying things)?

10. What are your usual leisure activities? _____

STRESSORS

11. What types of things make you feel stressed? _____

12. How do you deal with your stress normally? _____

DIETARY PATTERNS

13. How many meals/snacks do you eat in a day? _____
14. Do you eat breakfast? _____
15. Typically, do you eat after 8 p.m.? If so, what do you usually eat? _____
16. Do you feel you eat healthy “most of the time”? _____
17. Do you read food labels? _____
18. Do you ever eat when you aren’t hungry? If so, when _____
19. Do you “treat” yourself with food? If so, when _____
20. What sources from information have your found most helpful? _____
21. Do you eat in response to an emotion? If so, when _____

YOUR ATTITUDE TOWARD EXERCISE: What’s The Point of All of This Anyway?

You need to create a clear, tangible image in your mind of the benefits of staying on your fitness program. It must be vivid and powerful enough to sustain you through difficult times when you feel your self-discipline and motivation slipping. This exercise will help you create that image.

22. Complete this sentence: "If I do three cardiovascular exercise sessions and two to three resistance training sessions per week, it will . . ."

	Not likely					Very likely	
Improve my appearance	1	2	3	4	5	6	7
Allow me to cope with stress better	1	2	3	4	5	6	7
Help me avoid getting sick	1	2	3	4	5	6	7
Give me a powerful sense of personal achievement	1	2	3	4	5	6	7
Increase my self-esteem	1	2	4	4	5	6	7
Improve my physical strength	1	2	3	4	5	6	7
Make me more independent.....	1	2	3	4	5	6	7
Improve my ability to concentrate	1	2	3	4	5	6	7
Take up too much time	1	2	3	4	5	6	7
Cause pain, soreness, and discomfort	1	2	3	4	5	6	7
Make me very tired	1	2	3	4	5	6	7
Cause me to get injured	1	2	3	4	5	6	7

23. Do you need support from others to stay consistent with your exercise and nutrition program? _____
 Do you have this type of support? _____

24. Are there people in your life who either intentionally or unintentionally discourage or interfere your staying consistent in your exercise and/or nutrition program? _____ If so, how did they interfere? _____

If you answered "YES" to questions 23 or 24, how have you dealt with these situations in the past? What are your thoughts about how to improve these responses in the future?

	Not likely					Very likely	
"I think it is very likely that I will exercise five times a week.".....	1	2	3	4	5	6	7
"I think exercise is a waste of time for me.".....	1	2	3	4	5	6	7
"I know that I will be consistent with my fitness and nutrition program for six months.".....	1	2	3	4	5	6	7
"When I exercise, I look like dork.".....	1	2	3	4	5	6	7
"When I exercise, I always feel beat up afterwards.".....	1	2	3	4	5	6	7

EXPECTATIONS/GOALS

Specifically describe what your short and long term goals are through your fitness program.

SHORT TERM GOALS:

LONG TERM GOALS:
