HEALTH AND FITNESS QUESTIONNAIRE

All information is strictly confidential and used solely to design a safe and effective fitness program.

Personal Information:

- Full Name: _____
- Date of Birth: _____
- Phone Number: _____
- Email Address: _____
- Emergency Contact Name & Phone: _____

Medical History:

(Please check "Yes" or "No" and explain as necessary)

Condition/Question	Yes	No	Explanation
Heart condition, chest pain, or cardiac history?	□	□	
High blood pressure?	□	□	
Diabetes or thyroid problems?	□	□	
Asthma or respiratory issues?	□	□	
Bone/joint problems (e.g., arthritis, back pain)?	□	□	
Recent surgeries or hospitalizations?	□	□	
Are you currently pregnant or postpartum?	□	□	
Do you take medications regularly?	□	□	
Do you smoke?	□	□	
Have you been cleared by a medical provider for exercise?	□	□	

Fitness Goals:

- What are your top 3 fitness goals?
    1. _____
    2. _____
    3. _____
- How many days per week are you available to exercise? _____
- Do you prefer in-person or online sessions? _____
- Any past injuries that may affect performance? _____

Nutrition & Lifestyle:

- How would you describe your current diet?
    -

- Any dietary restrictions? _____
- How many hours of sleep do you get on average? _____
- Energy levels (scale 1–10): _____

Acknowledgment:

I affirm that the above information is true to the best of my knowledge and agree to notify Sunshine Elevations LLC of any changes in my health.

Client Signature: _____

Date: _____