Client History Health/Exercise Questionnaire

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell Phone: _____

Email address_____

Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Contact Phone Number(s): _____

How did you hear about us? _____

Health History

Do you now or have you in the past had:

1. History of heart problems, chest pain, or stroke _____
2. Increased blood pressure _____
3. High Cholesterol _____
4. Recent surgery (past 12 months) _____
5. History of breathing or lung problems _____
6. Muscle, joint, or back disorder or any previous injury still affecting you _____
7. Diabetes or thyroid condition _____
8. Hernia or any condition that may be aggravated by lifting weights _____
9. Any chronic illness or condition (osteoporosis, arthritis, cancer) _____
10. Are you taking any medications or drugs? _____
11. Do you suffer from dizziness or loss of consciousness? _____
12. Do you know of any reason why you should not exercise? _____

If you answered yes to any of the above questions, please explain below:

_____
_____
_____

Physical Activity

Please describe your fitness history.

_____
_____
_____

Are you presently involved in any type of fitness program? If yes, what types of activities are you involved in, how long of a period, and how many times a week?

_____
_____
_____

How can the staff make your exercise program more enjoyable?

_____
_____
_____

What are your leisure activities?

_____
_____
_____

How much time are you willing to devote to an exercise program? _____ minutes/day _____ days/week

How long have you been regularly exercising? _____ months _____ years

What are your health and fitness goals?

_____
_____
_____

Anything else I should know about you?

_____
_____