Medical and Activity Questionnaire

Personal Information

Name:______________________________ Date of Birth:________________ Age:_____
Phone number:______________________ Email:_________________________________
Height:_________ Weight:_________

In Case of Emergency Contact

Name:_____________________________ Relationship:______________Phone:________________

Medical History

Do you have any existing injuries or conditions that I should be aware of while building your training plan? __Yes__No If yes, please explain:____
Do you smoke tobacco products? __Yes__No
Are you currently under a doctor's care? __Yes__No. If yes, please explain:______________________
When was the last time you had a physical examination?_______________
Have you ever had an exercise stress test?__Yes__No__Not sure.
If yes, were the results:__Normal__Abnormal.
Do you take any medications on a regular basis?__Yes__No.
If yes, please list medications and reasons for taking:____
Check if YES for any of the following:

Have you had OR do you presently have any of the following conditions? (Check if YES).

__Rheumatic fever
__Edema (swelling of ankles)
__Injury to back or knees
__Seizures
__Heart attack
__Diabetes
__Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)
__Pain, discomfort in the chest, neck,

__Recent operation
__High blood pressure (>140/90)
__Low blood pressure
__Lung disease
__Fainting or dizziness with or without exertion
__High cholesterol
__Shortness of breath at rest or with mild exertion
__Chest pains
__Palpitations or tachychardia (unusally strong or rapid heartbeat)
__Intermittent claudication (calf cramping)
__Known heart murmur

jaw, arms, or other areas with or without physical exertion

__Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body

__Unusual fatigue or shortness of breath with usual activities

__Other___________________________________

Family history:

Have any of your first-degree relatives (parents, siblings, or child) experienced the following conditions? (Check if YES.) In addition, please identify at what age the condition occurred.

__Heart arrhythmia
__Heart operation
__Premature death before age 50
__Marfan syndrome
__High cholesterol
__Other major illness
__Heart attack
__Congenital heart disease
__Significant disability secondary to heart condition
__High blood pressure
__Diabetes

Explain checked items:____
____
____

Activity History

Are you currently engaging in regular physical activity? __I have never exercised regularly, __I used to exercise regularly, __I currently exercise regularly.
If yes, what type of activity?____
How many days per week?____
Have you ever worked with a trainer before?
Rate your overall activity level: __Sedentary, __Moderately active, __Active, __Very active.
Rate your experience with exercise: __Beginner, __Intermediate, __Advanced.
Rate your ability to perform cardio: __Very low, __Fair, __Average, __Good, __Excellent.
Can you currently walk 4 miles briskly without fatigue? __Yes __No

Activity Information

What are your goals?__Appearance, __Cardiovascular endurance, __Flexibility, __Health (general), __Muscular definition, __Muscular size, __Muscular strength/power, __Self-esteem or confidence, __Speed, __Sports performance, __Stress reduction, __Toning and shaping, __Weight loss, __Posture.

How many days per week would you be willing to work out?_______________________________
Which days are you available?____
What type of equipment is available to you?____
____
Would you like me to schedule your days or would you prefer to choose your days?_______________
Do you want to follow your own aerobic routine or do at least one aerobic session per week?
Any other comments about what you would like to see in your training plan?_____________________

I certify to the best of my knowledge the above information is correct and complete. I also understand that, ___________________________ assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. **All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.**

Signature:_______________________ Date:________________