

Health and Exercise History

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ Fax: _____

Emergency Contact: _____

Physician Name and Phone: _____

Age: _____ DOB: _____ Height: _____ Weight: _____

Exercise History

Have you ever participated in an exercise program? [] YES [] NO

If yes, what was your experience?

What other activities do you participate in?

Do you start exercise programs but find yourself unable to stick with them? [] YES [] NO

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

Can you exercise during your work day? [] YES [] NO

What types of exercise interest you?

- | | | | |
|--|-------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Running | <input type="checkbox"/> Swimming | <input type="checkbox"/> Cycling |
| <input type="checkbox"/> Dance | <input type="checkbox"/> Tennis | <input type="checkbox"/> Rowing | <input type="checkbox"/> Racquetball |
| <input type="checkbox"/> Strength training | <input type="checkbox"/> Stretching | <input type="checkbox"/> Other: | |

What do you want exercise to do for you? Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Reduce body fat |
| <input type="checkbox"/> Reshape your body | <input type="checkbox"/> Improve performance for a sport |
| <input type="checkbox"/> Improve mood and ability to cope with stress | <input type="checkbox"/> Improve flexibility |
| <input type="checkbox"/> Increase strength | <input type="checkbox"/> Increase energy level |
| <input type="checkbox"/> Other : | |

Health History

Are you currently taking any medications or drugs? [] YES [] NO

If yes, please list:

Medication: _____ Reason: _____ Dose: _____

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Do you have a history of or currently have heart problems, chest pain or stroke? [] YES [] NO

Does your immediate family have a history of heart problems? [] YES [] NO

Do you have increased blood pressure? [] YES [] NO

Have you been hospitalized or had surgery in the past year? [] YES [] NO

Do you have a hernia or any condition that may be aggravated by lifting weights? [] YES [] NO

Are you pregnant or have you given birth within the last three months? [] YES [] NO

Do you have a history of breathing or lung problems? [] YES [] NO

Do you smoke? [] YES [] NO

Do you have a muscle, back, kidney or joint disorder? [] YES [] NO

Have you experience an injury recently or in the past? [] YES [] NO

Do you have diabetes or a thyroid condition? [] YES [] NO

Do you have increased blood cholesterol? [] YES [] NO

Is there a health issue not mentioned in this questionnaire that would keep you from participating in regular exercise? [] YES [] NO

Please explain any "yes" answers below: