

# Health and Exercise History

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

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: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_ Dose: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_ Dose: \_\_\_\_\_

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: