

Q &A — Medical

On this questionnaire, a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. Please place a tick in the space to the left of the question to answer "Yes." Leave blank if your answer is "No." Please ask if you have any questions. Your responses will be treated in a confidential manner.

Name :: _____ Date :: _____

Date of Birth: / / Age:

Address:

STREET CITY STATE ZIP

Phone: (h) (o) (fax)

Email address:

Occupation:

Physician's Name: Physician's Phone:

Physician's Address:

STREET CITY STATE ZIP

GENERAL

1. Why did you choose Personal Training? Please check all that apply?

- | | | |
|--|--|---|
| <input type="checkbox"/> Lose Body Fat | <input type="checkbox"/> Develop Muscle Tone | <input type="checkbox"/> Rehabilitate an Injury |
| <input type="checkbox"/> Nutrition Education | <input type="checkbox"/> Start an Exercise Program | <input type="checkbox"/> Design a more advanced program |
| <input type="checkbox"/> Safety | <input type="checkbox"/> Sports Specific Training | <input type="checkbox"/> Increase Muscle Size |
| <input type="checkbox"/> Fun | <input type="checkbox"/> Motivation | <input type="checkbox"/> Other: |

When selecting your trainer, what criteria did you use?

- | | |
|---|--|
| <input type="checkbox"/> Referred by friend or acquaintance | <input type="checkbox"/> Watched trainer with others |
| <input type="checkbox"/> Read Bio in Program Guide | <input type="checkbox"/> Know trainer personally |
| <input type="checkbox"/> Degrees | <input type="checkbox"/> Certifications |
| | <input type="checkbox"/> Other: |

2. What would cause you to discontinue training with your Personal Trainer?

3. Medical History:

Please check any of the following conditions you now have or have experienced in the past: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart attack, coronary bypass | <input type="checkbox"/> other cardiac surgery | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Increased anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Emotional disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Fatigue or lack of energy | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Unusual shortness of breath | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Phlebitis, emboli |
| <input type="checkbox"/> Light-headedness or fainting | <input type="checkbox"/> Migraine or headaches | <input type="checkbox"/> Rheumatic fever |

- | | | |
|---|---|--|
| <input type="checkbox"/> Epilepsy, seizures | <input type="checkbox"/> Swollen, stiff or painful joints | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Chest discomfort |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Extra, skipped or rapid heart |
| <input type="checkbox"/> Flutters; palpitations | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Chronic or recurring cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Elevated cholesterol |
| <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Gave birth in last 6 months | |
| <input type="checkbox"/> Planning pregnancy | <input type="checkbox"/> Other: _____ | |

Please explain any checked items:

2. Do you take any medications (either prescription or non-prescription) or dietary supplements on a regular basis?
 Yes No If yes, please specify: _____

3. Please list any supplements or non-prescription medication you take on a regular basis:

LIFESTYLE

1. Do you smoke?
 Yes No If yes, how much? _____

2. Do you drink alcohol?
 Yes No If yes, how much? _____

3. How many hours do you regularly sleep at night? _____

4. Describe your job:
 Sedentary Active Physically Demanding

5. On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____

6. List your 3 biggest sources of stress:

a. _____ b. _____ c. _____

FITNESS:

1. When were you in the best shape of your life? _____

2. Have you been exercising consistently for the past 3 months?
 Yes No If yes, how much? _____

3. When did you first start thinking about getting in shape? _____

4. What if anything stopped you in the past? _____

5. On a scale of 1-10, how would you rate your present fitness level (1=worst 10=best)? _____

NUTRITION

1. On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? _____

2. How many times a day do you usually eat (including snacks)? _____

3. Do you skip meals?
 Yes No If yes, please specify: _____

4. Do you eat breakfast?
 Yes No If yes, please specify: _____

5. Do you eat late at night?
 Often Sometimes Never

6. What activities do you engage in while eating? (TV, reading etc) _____

7. How many glasses of water do you consume daily? _____

8. Do you feel decreases in your energy levels throughout the day?
 Yes No If yes, please specify: _____

9. Do you know how many calories you eat per day?
 Yes No If yes, please specify: _____

10. At work or school, do you usually:
 Eat out Bring food If yes, please specify: _____

11. How many times per week do you eat out? _____

12. Do you do your own grocery shopping?
 Yes No

13. Do you do your own cooking?
 Yes No

14. Besides hunger, what other reason(s) do you eat? (check all that apply)
 Boredom Social
 Stressed Tired
 Depressed Happy
 Nervous

15) Do you eat past the point of fullness?
 Often Sometimes Never

16) Do you eat foods high in fat and sugar?
 Often Sometimes Never

17) List 3 areas of your nutrition you would like to improve:

a. _____ b. _____ c. _____

18. Other comments:

Signature: _____

Date: _____

Fitness Trainer (please print): _____

Fitness Trainer Signature: _____