

Personal Training Health and History Questionnaire

Contact Information:

First: _____ M.I. _____ Last: _____
Date of Birth: _____ Home Phone: (____) _____ Other Phone: (____) _____
Address (1st line): _____
Address (2nd line): _____
City, State, Zip: _____
Email Address: _____

Healthcare Provider Information:

Name: _____ Specialty: _____
Address: _____
Street Address City State Zip
Phone Number: (____) _____
Emergency Contact: _____ Phone Number: (____) _____
Address: _____
Street Address City State Zip
Relation: _____

Employment Information:

Status (Circle One): EMPLOYED UNEMPLOYED RETIRED
Company/Employer: _____

Medications:

Specific Medications: Please list all medication currently being taken. These may include prescription and over the counter medications and/or supplements.

Medication Name	Dosage (amount)	Frequency (times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgery Information:

Please indicate any surgery you have had. Please include the type of surgery or intervention, and the approximate date.

Description of Surgery	Approximate Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Has a parent, brother, sister, or child in your biological family developed any of the following? Please check all that apply.

- Heart attack under age 55 if male or 65 if female
- Bypass surgery under age 55 if male or 65 if female
- Angioplasty under age 55 if male or 65 if female
- Stent placement under age 55 if male or 65 if female
- Angina under age 55 if males or 65 if female
- Stroke under age 55 if male of 65 if female
- High cholesterol or triglycerides
- Diabetes
- Cancer Type _____
- Family history is unknown (wholly or in part)
- Confirmation Only: None of the above conditions apply to my family history.

Past Injuries:

Please list any previous injury accompanied by a brief explanation and approximate time that it occurred. Please include any injury related to bone, joint, muscle, nerve, etc.

Medical Issues:

Please check all significant medical issues that apply to you. These may be either past or present issues. Please include the approximate date of onset, and whether or not the issue is presently affecting you.

	Year of Onset	Still an Issue?	Comments
General:			
<input type="checkbox"/> Chronic fatigue	_____	_____	_____
<input type="checkbox"/> Any type of cancer	_____	_____	_____

	Year of Onset	Still and Issue?	Comments
Cardiac:			
<input type="checkbox"/> Angina	_____	_____	_____
<input type="checkbox"/> Shortness of breath	_____	_____	_____
<input type="checkbox"/> Heart attack	_____	_____	_____
<input type="checkbox"/> Bypass surgery	_____	_____	_____
<input type="checkbox"/> PTCA/Stent	_____	_____	_____
<input type="checkbox"/> Heart valve surgery	_____	_____	_____
<input type="checkbox"/> Heart transplant	_____	_____	_____
<input type="checkbox"/> Pacemaker/ICD	_____	_____	_____
<input type="checkbox"/> Congenital defect	_____	_____	_____
<input type="checkbox"/> Congestive Heart Failure	_____	_____	_____
<input type="checkbox"/> Cardiomyopathy	_____	_____	_____
<input type="checkbox"/> Heart murmur	_____	_____	_____
<input type="checkbox"/> Aortic aneurysm	_____	_____	_____
<input type="checkbox"/> Ankle swelling	_____	_____	_____
<input type="checkbox"/> Rapid/Irregular heart rate	_____	_____	_____
<input type="checkbox"/> Fainting/Syncope	_____	_____	_____
<input type="checkbox"/> High blood pressure	_____	_____	_____
<input type="checkbox"/> Stroke	_____	_____	_____
<input type="checkbox"/> High cholesterol	_____	_____	_____
<input type="checkbox"/> Arterial Blockage	_____	_____	_____
Endocrine:			
<input type="checkbox"/> Thyroid disease	_____	_____	_____
<input type="checkbox"/> High blood sugar	_____	_____	_____
<input type="checkbox"/> Diabetes Type I or II	_____	_____	_____
<input type="checkbox"/> Kidney/Renal Disease	_____	_____	_____
Pulmonary:			
<input type="checkbox"/> Asthma	_____	_____	_____
<input type="checkbox"/> Chronic bronchitis	_____	_____	_____
<input type="checkbox"/> Emphysema	_____	_____	_____
<input type="checkbox"/> COPD	_____	_____	_____
Gastrointestinal:			
<input type="checkbox"/> Ulcer disease	_____	_____	_____
<input type="checkbox"/> Gallbladder disease	_____	_____	_____
<input type="checkbox"/> Hepatitis or cirrhosis	_____	_____	_____
Neuropsychiatric:			
<input type="checkbox"/> Seizures	_____	_____	_____
<input type="checkbox"/> Numbness in face or limbs	_____	_____	_____
<input type="checkbox"/> Depression	_____	_____	_____
<input type="checkbox"/> Anxiety	_____	_____	_____
Hematology:			
<input type="checkbox"/> Anemia	_____	_____	_____
<input type="checkbox"/> Blood Clots	_____	_____	_____
<input type="checkbox"/> Bleeding Disorder	_____	_____	_____
<input type="checkbox"/> HIV/AIDS	_____	_____	_____

Lifestyle and Nutrition:

Do you currently smoke? _____ If yes, how often? _____
 Have you quit smoking? _____ If yes, how long ago? _____
 Do you consume alcohol? _____ If yes, how often? _____
 How many caffeinated drinks do you consume per day (coffee, soda)? _____
 Are you currently on a diet? _____
 How many meals do you eat in a typical day? _____
 Do you consider yourself -- OVERWEIGHT ABOUT RIGHT UNDERWEIGHT
 Do you feel your nutrition habits are -- GOOD FAIR POOR
 Do you feel your nutrition knowledge is -- GOOD FAIR POOR
 Is your job active or sedentary? _____
 Do you have a large amount of stress? _____
 Do you feel your knowledge of exercise is -- GOOD FAIR POOR
 Do you feel your physical condition is -- GOOD FAIR POOR

Exercise History and Goals:

Are you presently involved in an exercise program? _____
 How much time can you devote to exercise? _____ days/week _____ time

Trainer Preference: MALE FEMALE
 Name of Trainer if you have a preference: _____

What type of activities do you like/enjoy?

What type of activities do you dislike?

What do you want to accomplish by exercising (i.e. increase strength, increase cardiovascular or muscular endurance, weight loss, disease management, increase flexibility, stress reduction, etc.)?

Anything Else?

I, _____ (initials) understand that personal training given by the Shoreline Wellness Center is for general wellness purposes, and to promote overall health maintenance and improvement. I understand that the personal training staff will not diagnose any musculoskeletal or nervous system issue, disease or disorder. I understand that I should see a licensed healthcare provider for diagnosis of any medical issue. I also understand that it is my responsibility to inform the training staff of any medical conditions I may have, and keep the staff posted with respect to any changes in my health history profile. I authorize the performance of personal training techniques and may be refused training if I appear under the influence of drugs or alcohol. ***I understand that personal training is a fee based service and I understand and agree that cancellations made less than 24 hours prior to my reserved time are subject to a cancellation fee equivalent to my reservation. If a trainer must cancel my reservation with less than 24 hours notice, it will be re-scheduled and performed at no cost.***

Signature: _____ Date: _____

This information is confidential, however it may be shared with relevant Shoreline Wellness Center and South Haven Community Hospital representatives.