ONLY THE STRONG FITNESS

HEALTH STATUS QUESTIONNAIRE

______________________________ Name
__________ Date

__________ Date of Birth
__________ Age

______________________________ Street Address
_________________________ Primary Phone Number

______________________________ City, State, Zip
_________________________ Secondary Phone Number

______________________________ Email

______________________________ Emergency Contact /Relationship
_________________________ Emergency Contact Phone

______________________________ Physician
_________________________ Physician Number

How did you hear about our personal training program?
_____Website _____Other (Please Specify):_____________________________

MEDICAL AND HEALTH STATUS QUESTIONNAIRE

Throughout this questionnaire, a number of questions regarding your physical health and activity level are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. Place a check in each space to the left of the question to respond “Yes”. Leave question blank if answer is “No”. All answers will be treated in a confidential manner.

Medical Screening

□ Personal history of heart disease (coronary or atherosclerotic disease)?
□ Personal history of diabetes or other metabolic disease (thyroid, renal, liver)?
□ Personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?
□ Experienced pain or discomfort in your chest apparently due to blood flow deficiency?
□ Unaccustomed shortness of breath (possibly during exercise)?
□ Difficulty breathing while standing or sudden breathing problems at night?
□ Rapid throbbing or fluttering of the heart?
□ Experienced severe pain in leg muscles during walking?
□ Suffer from ankle edema (swelling of the ankles)?
□ Known heart murmur?
□ Serum cholesterol measured at greater than 200 mg/dl?
□ Characterize your lifestyle as “sedentary”?
□ High fasting blood glucose level on 2 or more occasions (>110 mg/dl)?
□ 20% or more overweight or have you been told your “BMI” was greater than 30?
□ Assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90 mmHg)?
□ Any family history of cardiac or pulmonary disease prior to age 55?

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☐ Are you currently being treated for high blood pressure?
-If so, do you know your average blood pressure? _____/_____

Medical History

Please check any and/or all conditions/diagnoses that apply:

□ Abnormal ECG
□ Abnormal Chest X-Ray
□ Rheumatic Fever
□ Low Blood Pressure
□ Asthma
□ Bronchitis
□ Emphysema
□ Other Lung problems:
□ Recently broken Bones:
□ Limited Range of motion
□ Arthritis
□ Bursitis
□ Swollen or Painful Joints
□ Foot problems
□ Knee problems
□ Back problems
□ Shoulder problems
□ Stroke
□ Epilepsy or Seizures
□ Chronic Headaches or Migraines
□ Persistent Fatigue
□ Stomach Problems
□ Hernia
□ Anemia
□ Currently Pregnant

☐ Has a doctor imposed any physical restrictions if above box(s) have been checked? If so, please explain:____

Family History

Has any family member suffered from any of the following? (Please check all that apply):

□ Heart attack or Heart surgery before age 55
□ Congenital Heart disease
□ Hypertension
□ High Cholesterol
□ Diabetes
□ Obesity
□ Asthma
□ Musculoskeletal Problems
□ Cancer prior to age 60
□ Stroke prior to age 50

Medications

Please select medications that you are currently using:

□ Alpha Blockers □ Vasodilators □ Beta Blockers □ Other Cardiovascular
□ Calcium Channel blockers □ Cholesterol □ Diuretics
□ NSAIDS/Anti-Inflammatories (Motrin, Advil) □ Diabetes/Insulin
□ Other Drugs (record below)

Please list specific medications that you are currently taking/or were not in the chart:
____

Lifestyle

Are you a cigarette/cigar smoker? If so, how may per day do you smoke?____________
☐ Previously a cigarette smoker? If so, when did you quit?

Please Rate your daily stress level (select one):
☐ Low
☐ Moderate
☐ High-but not unmanageable
☐ High-sometimes difficult to manage
☐ High-too difficult/unmanageable

☐ Do you drink alcoholic beverages?

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HEALTH AND FITNESS GOALS

Below are some questions that will help the provider learn more about your health and fitness goals. Should you have any questions, feel free to consult with your personal trainer.

Please indicate your personal health and fitness related goals: (Check all that apply)
□ Aerobic Fitness □ Feel better □ Improve Flexibility □ General Fitness
□ Improve Diet □ Injury Rehab □ Look Better □ Lose Weight
□ Lower my Cholesterol □ Muscular Size □ Muscular Strength □ Reduce Back Pain
□ Reduce Stress □ Sports Specific □ Stop Smoking □ Other
If other was checked, please explain:
____
____
____

Is there someone that will be able to act as a support system for your exercise goals? If so, who?
____

Recent Exercise schedule:
Average hours per week exercising?_________
Average length of work-out?__________(minutes)
Intensity of a work-out (Scale of 1-10: 1 being easy-10 hardest)__________
How long have you worked out on a regular basis?_________(years)

A typical week of exercising consists of what exercises? (Check all that apply and how long you work in minutes):
□ Running/Jogging:_______ □ Walking:______ □ Biking/Spinning:_______
□ Stair Climbing:_______ □ Weight Training:_______ □ Aerobics :_______
□ Swimming:_______ □ Racquet Ball:_______ □ Yoga/Pilates:_______
□ Other: (Please specify)____