Personal Training Health Screening Questionnaire

Personal Information

Today's date:_____

Title: O DR. O Mr. O Mrs. O Ms.

Name: _____ _____ Birth date: _____

First Name Last Name Age: _____

Address: _____ Phone: (Home) _____

City: _____ Phone: (Work _____

Email: _____ Phone: (Cell) _____

Occupation:_____

Gender: Male_____ Female_____ Height: _____ Weight: _____

Person to contact in case of emergency: _____ Tel:_____

Physician's Name: _____Tel: _____

Medical History

Please indicate if any of these statements apply to you by placing YES in the space provided

(* past or current):

1. History of heart problem (i.e. Chest pain, heart murmur, or stroke) _____
2. Diabetes Mellitus _____
3. Asthma, breathing, or lung problems _____
4. Allergies _____
5. Cancer (other than skin) _____
6. Seizures, seizure medication, neurological problems, dizziness _____
7. High blood pressure _____
8. Back problems, joint or muscle disorder still affecting you _____
9. Recent surgery (last 12 months) _____
10. Hernia or any condition that may be aggravated by exercise _____
11. Physician's advice not to exercise _____
12. History of high cholesterol _____

13. Family history of coronary heart disease? _____
14. Do you smoke tobacco products _____
15. Do you consume alcohol? _____
16. Do you take supplements of any kind? _____
17. Are you on medication? _____
18. Do you have joint problems that might be aggravated by exercise? _____
19. Is stress from daily living an issue in your life? _____

Skeletal Injuries

Back_____
Neck_____
Head_____
Knee(R, L) _____
Shoulder(R, L) _____
Other injuries: _____
Surgery: _____

Please describe any special considerations or how your injury currently affects your ability to function: (i.e. Illness or Injury)

_____
_____

Please talk with your doctor by phone or in person before you start any new training program or have a fitness assessment. Tell your doctor about your health questionnaire and which questions you answered yes.

Goals

1. What are your concerns and goals? 9 example: fat loss, strength, power, muscular endurance, cardio fitness, flexibility, agility, core stability or balance)

_____
_____
_____

2. Why do you want to achieve these goals? (Examples: general health, injury prevention/rehab, sport –specific training, aesthetic reasons)

_____
_____
_____

3. What areas do you want to concentrate on or emphasize? (i.e. specific areas to strengthen, joint stability, cardio or core conditioning)

_____

_____

_____

Fitness History

4. How long has it been since you have exercised regularly? (2 or more times/week).

_____

5. Do you have experience with free weights or functional stability training?

_____

6. What type of cardiovascular exercise are you familiar with?

_____

7. If you are an experienced exerciser or athlete, what exactly is your current program?_____

_____

8. Are there any exercises that are contraindicated or not recommended by your physician or physical therapist?_____

_____

9. How would you describe your level of daily activities? Please check one.
Light (office work)__ Moderate(Manual labor)__ Heavy (construction)__

10. Stress (high=5, low=1) please circle one.
Physical 1 2 3 4 5 Personal/ Emotional 1 2 3 4 5 Mental/Career 1 2 3 4 5

11. Present method of handling stress:

_____

_____

12. Number of hours of sleep per night?_____

13. What is your available time and frequency for exercise?
What days: M T W TH F
What times: AM_____ PM_____

14. Any special considerations or requests?

_____

_____

_____

_____