

Health & Lifestyle Questionnaire

Name: _____

Address: _____

Telephone: (H) _____ (W) _____ (Email) _____

Emergency number to call: _____ Date of Birth: _____

In order to design a safe and effective fitness program it is important

that you complete the following Health History.

It is crucial that you answer all the questions honestly and to the best of your ability.

Please be advised that all information is kept strictly confidential.

A. Check the appropriate response. Read all questions thoroughly.

	YES	NO
1. Has your doctor ever told you that you have a heart problem?	_____	_____
2. Has your doctor ever told you that you have high blood pressure?	_____	_____
3. Have you ever had a stroke or heart attack?	_____	_____
4. Have you ever had pain in your chest?	_____	_____
5. Do you ever feel faint or have dizzy spells?	_____	_____
6. Have you had surgery in the last six months?	_____	_____
7. Do you have any bone or joint problems?	_____	_____

B. Check the appropriate conditions.

Diabetes _____ Diabetes _____ Asthma/Bronchitis/Emphysema _____
Arthritis _____ Osteoporosis _____ High Cholesterol _____
Pregnancy _____ Epilepsy _____ Heart Disease/Hypertension _____
Varicose Veins _____ Back Pain _____

Family Physician: _____ **Office #:** _____

Specialist (physiotherapist/chiropractor/massage therapist): _____

Name: _____ **Office #:** _____

C. Have you injured or have pain in the following areas? _____ Check the appropriate lines.

Neck _____ Upper Back _____ Shoulders _____ Elbows _____
Lower Back _____ Hips _____ Wrists _____ Knees _____

If yes, please explain:

D. Are you currently taking any medications? Yes _____ No _____

If you checked 'yes', please list medications, dosage, and for what condition.

Medication _____ Dosage _____ Condition _____

Medication _____ Dosage _____ Condition _____

E. Are there any other reasons (health or personal) that may limit or prevent you from exercising?

Please be advised that certain health restrictions may require you to obtain medical clearance from your physician before training can begin.

F. What is your current exercise level?

Type of Activity: _____ Started How Long Ago: _____
Times per week: _____ Length of Activity Session: _____

G. What are your exercise goals? Please number in order of importance: #1, being most important.

Weight loss _____ Weight gain _____ Posture _____ Stress Reduction _____
Increase strength _____ Cardiovascular conditioning _____
Other: _____

H. How would you rate your level of stress on a daily basis?

Low _____ Moderate _____ High _____

Type of Occupation: _____

I. Are you currently following any type of special diet? _____

If yes, which type of diet are you following?:

Reduced calorie _____ Increased calories _____ Low fat _____
Low cholesterol _____ High Protein _____ Low Carbohydrate _____
Other: _____

J. Do you regularly eat: breakfast _____ lunch _____ supper _____ snacks _____

Do you eat from the four food groups?:

milk & milk products _____ breads & cereals _____ fruits & vegetables _____ meat/fish/poultry _____

K. Estimate how many hours of sleep you get each night: _____

L. Do you smoke?: _____ If yes, how long _____ how many per day _____

Other relevant information: _____

Date: _____ Signed by: _____ Witness _____