



Date: _____

Health History and Physical Activity Form

Name: _____
(Parent Name if under 18) _____

Address: _____

Age: _____
DOB: _____

Home # _____
Cell # _____
Work # _____
E-mail _____
Occupation _____

Emergency Contact:
Name: _____
Phone: _____

Height: _____ Weight: _____

Please check if applicable:

	Yes	No	If yes, describe
Diabetes	_____	_____	_____
High blood pressure	_____	_____	_____
High cholesterol	_____	_____	_____
Heart attack	_____	_____	_____
Family history of heart problems	_____	_____	_____
Angina/chest pains	_____	_____	_____
Irregular heart beat	_____	_____	_____
Valve disease	_____	_____	_____
Stroke	_____	_____	_____
Thyroid problems	_____	_____	_____
Asthma	_____	_____	_____
Respiratory problems	_____	_____	_____
Hernia	_____	_____	_____
Arthritis	_____	_____	_____
Pregnancy/now or past 3 months	_____	_____	_____
Hospitalized recently	_____	_____	_____
Recent surgery	_____	_____	_____
Smoke/use tobacco	_____	_____	_____

Rate your current health 1=unhealthy / 5=very healthy _____

Do you have any of the following conditions that may limit your physical activity?

- | | | | |
|------------------|-------------------|------------------|----------------|
| ___ ankle/foot | ___ bone fracture | ___ shoulder | ___ wrist/hand |
| ___ low back | ___ arm/elbow | ___ tennis elbow | ___ knee |
| ___ hamstring | ___ hip/pelvic | ___ upper back | ___ head/neck |
| ___ nerve damage | ___ other _____ | | |

Explain conditions: _____

- Has your physician advised you against exercise? ___yes ___no
- Are you presently receiving physical therapy? ___yes ___no
If so, for what condition. _____
- Are you presently taking any medications? ___yes ___no
Please list: _____
- Have you ever had a stress test? ___yes ___no
If so, date of most recent test _____ ___normal ___abnormal
- Have you had a significant weight loss or gain the past year? ___yes ___no
Explain: _____

Lifestyle History

- How many hours of sleep do you regularly sleep at night? _____
- How would you rate your daily stress level? 1=very low / 10=very high: _____
- How would you rate your daily physical demands? 1=very low / 10=very high: _____

Fitness History

- Have you been exercising consistently for the past 6 months? ___yes ___no
If yes, what activities and how often. _____
- On a scale of 1-10, how would you rate your present fitness level?
1=poor / 10=excellent _____
- If your participation in physical activity is lower than you would like it to be, what are the reasons?

- Rate your level of flexibility. 1=very tight / 10=very flexible _____
If any, describe your flexibility problem areas. _____

Developing Your Fitness Program

How often a week is your goal to exercise? _____
What type of exercise do you like? _____

Exercise Availability / List available times: (a.m. & p.m.)

Monday	_____	Tuesday	_____
Wednesday	_____	Thursday	_____
Friday	_____	Saturday	_____

What are your reasons for personal training? (circle)

Lose body fat	Develop muscle tone	Muscle strength	Stress relief
Need a direction	Need more advanced program	Motivation	Social
Increase muscle size	Rehab an injury	Sport specific	

- List any home equipment you have: _____
- How did you hear about me? _____

Participant's Signature: _____ **Date:** _____
(Parent's Signature is under 18) _____

***If your medical condition changes, it is your responsibility to inform your trainer.**