Fitness Your Weigh
Health/Fitness Questionnaire

Date: __________ Birthday (M/D)___/____
Name:____ Age:______
Address:____________________________________ City:__________ State:_______
Zip Code: ____________ Phone: Home ____________Cell____________ Txt ok? Y N
Email____

Person to notify in case of Emergency

Name:____ Relation:____________
Phone: _________________________

Date of last physical exam: ___________________________ OK'd to exercise? Y N
Present Physician: ______________________ Phone/Fax: ______________________
Address:________________________________ City: _________________State:______

Check if "YES" and Explain

Past	or Present	Condition	Further Explanation / Medications
( )	( )	Allergies	______________________________________
( )	( )	Arthritis/Bursitis/ Tendonitis	______________________________________
( )	( )	Back/Neck Pain/Injuries	______________________________________
( )	( )	Injuries to Knees, Hips, Shoulders, Ankles, etc.	______________________________________
( )	( )	Asthma / Lung / Respiratory Diseases	______________________________________
( )	( )	Cancer	______________________________________
( )	( )	Diabetes	______________________________________
( )	( )	High Cholesterol >240	______________________________________
( )	( )	High Triglycerides	______________________________________
( )	( )	High Blood Pressure	______________________________________
( )	( )	Heart Disease	______________________________________
( )	( )	Chest Pain (Angina)	______________________________________
( )	( )	Embolism (blood clot)	______________________________________
( )	( )	Stroke	______________________________________
( )	( )	Epilepsy	______________________________________
( )	( )	Osteoporosis/ Scoliosis	______________________________________
( )	( )	Frequent Headaches/ Fainting	______________________________________
( )	( )	Muscle Cramps/Spasms	______________________________________
( )	( )	Pregnancy	______________________________________
( )	( )	Lyme Disease	______________________________________
( )	( )	Other	______________________________________

Family Medical History (immediate relatives under age 55)

( ) Heart Attack ( ) Diabetes ( ) Stroke
( ) High Blood Pressure ( ) High Cholesterol ( ) Coronary Disease

1. Please list any other medications that you are taking and the corresponding conditions:
   ______________________ ______________________

2. Do you now, or have you ever smoked? If yes how much per day? ( )yes ( )no
   ____

3. Do you use alcohol? If yes how much per week? ( )yes ( )no
   ____

4. Do you drink/use caffeine? If yes how much per day? ( )yes ( )no
   ____

5. How many hours do you work per week on average? __________
   How would you characterize your work activity?
   ( ) inactive ( ) semi-active ( )active ( ) heavy labor

6. How do you characterize your lifestyle in regards to stress?
   ( ) Low ( ) Moderate ( ) High

7. **Nutritional Habits**: Please rate yourself using the following 3 factors.
   A) Frequency- please circle the number of times you eat each day on average
      1 2 3 4 5 6 7
   B) Portion size – are most of your meals large or small?
      1 2 3 4 5
      smallest largest
   B) Quality – do you eat a balanced diet? Do you eat healthy foods?
      1 2 3 4 5
      poor excellent

8. Please describe your current exercise/activity level:
   ____
   ____
   ____
   ____

9. How did you hear about us? ____

10. Please describe your short and long term goals. Why are you here?
   ____
   ____
   ____
   ____
   ____

11. Trainer Notes/Action Plan:
   ____
   ____
   ____
   ____
   ____
   ____
   ____