HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your answers will be kept confidential between you and Transformation Fitness Certified Fitness Training.

Name: _____ Date of Birth: _____/_____/_____
Address: _____
City, State, Zip: _____
Home Phone: _____ Work/Cell Phone : _____
Email address: _____
Employer: _____ Occupation: _____

Physician: _____ Phone: _____
Address: _____
City, State, Zip: _____

In case of emergency, please notify:
Name: _____ Relationship: _____
Address: _____
City, State, Zip: _____
Phone: _____

1. Are you under the care of a physician, chiropractor, or other health care professional for any reason? ☐ **Yes** ☐ **No**
If yes, list reason: _____
_____
_____
_____

2. Are you taking any medications? ☐ **Yes** (*if yes, please complete the following)* ☐ **No**

Type	Dosage/Frequency	Reason for Taking

3. Please list any allergies: _____

_____
_____

I am not aware of any disease or disorder that would complicate my participation in a testing or exercise program, other than the medical conditions I have checked below.

Age: _____ Gender: M F

Note: In order to assist you in the development of a rewarding physical fitness program, we need to have your honest and accurate responses.

1. Has your doctor ever said your blood pressure was too high? **Yes** **No**

2. Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise? **Yes** **No**

3. Are you over age 65? **Yes** **No**

4. Are you accustomed to vigorous exercise? **Yes** **No**

5. Is there any reason not mentioned here why you should not follow a regular exercise program? **Yes** **No**
If so, please explain._____
_____
_____

6. Have you recently experienced any chest pain associated with either exercise or stress? **Yes** **No**
If so, please explain. _____
_____
_____

7. Do you have a family history (blood relatives only) of any of the following conditions?

	Yes	**No**
____ Heart Disease		____ Heart Attack
____ Hypertension		____ High cholesterol
____ Gout		____ Angina
____ Abnormal EKG		____ Diabetes
____ Asthma		____ Other heart condition

8. FEMALES ONLY

a) Are you menstruating regularly?	**Yes**	**No**
b) If yes, do you experience severe cramping or an abnormally heavy flow?	**Yes**	**No**
c) If you answered no for question A, have you gone through menopause?	**Yes**	**No**
d) Are you pregnant?	**Yes**	**No**

SMOKING

Please check the box that best describes your current habits:

- ☐ Non-user or former user. Date quit: _____
- ☐ Cigar and/or pipe
- ☐ 15 or less cigarettes per day
- ☐ 16 to 25 cigarettes per day
- ☐ 26 to 35 cigarettes per day
- ☐ More than 35 cigarettes per day

FAMILY HISTORY OF CARDIOVASCULAR DISEASE (CV)

Please check the boxes that best describe your personal family history (blood relatives only):

- ☐ No known history of heart disease in family
- ☐ One relative over age 60 with CV disease
- ☐ Two or more relatives over age 60 with CV disease
- ☐ One relative under age 60 with CV disease
- ☐ Two relatives under age 60 with CV disease
- ☐ Three relatives under age 60 with CV disease

MUSCULOSKELETAL

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

Head/neck _____
Upper back _____
Shoulder/clavicle _____
Arm/elbow _____
Wrist/hand _____
Lower back _____
Hip/pelvis _____
Thigh/knee _____
Lower leg/ankle/foot _____

NUTRITIONAL

Are you on any specific food/nutritional plan at this time? ☐ **Yes** ☐ **No**
If yes, please list:_____

Do you take any dietary supplements? ☐ **Yes** ☐ **No**
If yes, please list: _____

Do you experience any frequent weight fluctuations? ☐ **Yes** ☐ **No**

Have you experienced a recent weight gain or loss? ☐ **Yes** ☐ **No**
If yes, list change: _____ Over how long? _____

How many beverages do you consume per day that contain caffeine? _____

How many beverages do you consume per day that contain alcohol? _____

EXERCISE

Please check the box that best describes your work and exercise habits:

- ☐ Intense occupational and recreational exertion
- ☐ Moderate occupational and recreational exertion
- ☐ Sedentary work and intense recreational exertion
- ☐ Sedentary work and moderate recreational exertion
- ☐ Sedentary work and light recreational exertion
- ☐ Complete lack of all exertion

To what degree do you perceive your environment as stressful?

_____ Minimal _____ Moderate

_____ Average _____ Extremely

Please make any other comments you feel are pertinent to your exercise program.

_____

_____

_____

_____

_____

_____

_____

_____ Date: _____

Signature of client

_____ Date: _____

Signature of Parent or guardian (if under 18)

_____ Date: _____

Signature of Witness