PERSONAL HEALTH HISTORY

Name_____Date_____

Address_____

Home phone _____Work phone_____

Emergency contact name and phone number _____

E-mail address _____

Gender Male _____ Female _____

Age _____ Birth date _____ Weight _____ Height_____

Physician's name _____ Physician's phone _____

Does your physician know that you are participating in an exercise/fitness program?
Yes ____ No ____

Date of last physical examination _____

Are you taking any medications?
No ____ Yes ____ (Please list medications and reasons for usage below)

Medications and Reason for usage

Are you taking any vitamins or dietary supplements?
No ____ Yes ____ (Please list supplements and reasons for usage below)

Supplement and Reason for usage

Do you now, or have you had in the past:	YES	NO
1. History of heart problems, chest pain or stroke?		
2. Increased blood pressure?		
3. Any chronic illness or condition?		
4. Do you ever get dizzy, lose your balance or lose consciousness?		
5. Difficulty with physical exercise?		
6. Advice from physician not to exercise?		
7. Surgeries?		
8. Pregnancy (now or within last 3 months)?		
9. History of breathing or lung problems?		
10. Swollen, stiff, or painful joints?		
11. Foot problems?		
12. Back problems?		
13. Any significant vision or hearing problems?		
14. Diabetes or thyroid condition?		
15. Cigarette smoking habit? If yes, how long have you or did you smoke _____		
16. Do you ever drink alcoholic beverages?		
17. Increased blood cholesterol?		
18. History of heart problems in immediate family?		
19. Hernia, or a condition that may be aggravated by lifting weights?		
20. Do you have asthma?		
21. Migraines or chronic headaches?		
22. Any type of Cancer?		

Please explain any yes answers below. (If necessary use the back of this page)_____

Do you have any other medical conditions or problems not previously mentioned? If so, please explain._____

FAMILY HISTORY

Have any of your BLOOD relatives had:	YES	NO
1. Heart attack under age 50?		
2. Stroke under age 50?		
3. High blood pressure?		
4. Elevated cholesterol?		
5. Diabetes?		
6. Asthma or hay fever?		
7. Heart operations?		
8. Obesity?		
9. Leukemia or cancer under age 60?		
10. Cancer? If yes, what type?		

EXERCISE AND PHYSICAL ACTIVITY

For the following questions, please mark which best applies to you.

Are you currently exercising on a regular basis? yes ___ no ___

If yes, what type of exercise and how often? _____

For the following questions, mark which best applies to you.

Do you consider yourself:
___ sedentary
___ lightly active (sporadic workouts, lawn work, little aerobic work)
___ moderately active (work out 1-2 days/week for at least 15-30 minutes)
___ highly active (work out three or more days/week at least 30-45 minutes)

Indicate the main reason you exercise or why you want to begin an exercise program.

___ it is good for my health
___ my doctor told me to
___ it makes me feel good
___ helps to relieve stress
___ I am trying to lose weight
___ other _____

GOAL ASSESSMENT

Name _____ Date _____

Goals should be: **SMART** (example goal: I want to lose 2 percent body fat within 6 months.)

S ~ Specific: *What will you do?* (i.e. lose weight)
M ~ Measurable: *How will you measure it?* (i.e. percent body fat, BMI)
A ~ Attainable: *Is this something you can attain?*
R ~ Realistic: *Can you realistically reach this goal?*
T ~ Set on a time line: *When do you want to reach this goal?*

Please fill out the goals and objectives below. You may want to wait and set these goals with the guidance of your personal trainer.

Long term goals (Where do you want to be in 6 months to a year?)

1._____

2._____

3._____

Short term objectives (What small things will you do to accomplish your long term goals?)

1._____

.

2._____

3._____

4._____

Mental Health Goals (improvements you may want to make in your sleeping habits, stress, tension and anxiety levels.)

1. _____

_____

2. _____

_____

3. _____

_____