HEALTH and PHYSICAL ACTIVITY HISTORY

Name: _____ Trainer: _____
Address: _____ Age: _____ Birthdate: _____
_____ Sex: _____ Height: _____
_____ Weight: _____
Phone: Home (___)_____ Business (___)_____
Physician's Name: _____ Phone: _____
Address: _____
Emergency Contact-Name/Relationship:_____ Phone: _____

1. Please check if applicable:

	CLIENT		FAMILY		IF YES, DESCRIBE
	YES	NO	YES	NO	
Diabetes	___	___	___	___	_____
High Blood Pressure	___	___	___	___	_____
High Cholesterol	___	___	___	___	_____
Heart Attack	___	___	___	___	_____
Angina/Chest Pain	___	___	___	___	_____
Heart Murmur	___	___	___	___	_____
Irregular Heart Beats	___	___	___	___	_____
Abnormal Electrocardiogram	___	___	___	___	_____
Rheumatic Fever	___	___	___	___	_____
Thrombophlebitis	___	___	___	___	_____
Respiratory Infections	___	___	___	___	_____
Asthma	___	___	___	___	_____
Embolism	___	___	___	___	_____
Aneurysm	___	___	___	___	_____
Stroke	___	___	___	___	_____
Valve Disease	___	___	___	___	_____
Epilepsy	___	___	___	___	_____

2. Do you have any of the following conditions that may limit your physical activity? (Please check if applicable.)

___ Arthritis	___ Ankle/Foot Injury	___ Bone Fracture
___ Wrist/Hand Injury	___ Low Back Pain	___ Shoulder/Clavicle Injury
___ Arm/Elbow Injury	___ Knee/Thigh Injury	___ Hip/Pelvic Injury
___ Calcium Deposits	___ Nerve Damage	___ Tennis Elbow
___ Upper Back Injury	___ Head/Neck Injury	___ Other

If Other, please explain:_____
_____

3. Has your physician ever advised you against exercise?
___ Yes ___ No If Yes, why? _____
_____

4. Are you presently receiving physical therapy? ___ Yes ___ No

5. Are you presently taking any medications? (Include over-the-counter medications.)
___ Yes ___ No If Yes, please list names and dosages of each: _____
_____

6. Social History: ___Married ____Divorced ____Single Siblings #_____ Children # ____
Parents: Mother/Father: Living (age)_____ Deceased (age) _____
Do you use? Caffeine: _____ Type: _____ Amt. (cups) _____
Tobacco:_____ # of yrs. _____ Amt/Day _____ Quit Date_____
Alcohol: Beer(oz/wk)_____ Wine(oz/wk)_____ Hard Liquor (oz/wk) _____

7. Are you involved in an exercise program at the present time? ___ Yes ___ No
If yes, please describe the program:_____
_____

8. How would you rate the amount of physical activity at work?
___ Very Little ___ Little ___ Moderate ___ Active ___ Very Active

9. How would you rate the stress level of your job?
___ Little ___ Moderate ___ Stressful

10. When exercising, including climbing stairs, do you ever experience any of the following?
___ Chest Pains ___ Pressure Over the Heart ___ Shortness of Breath
___ Leg Aches ___ A Tired-Out Feeling ___ Dizziness

11. Have you ever had a stress test? ___ Yes ___ No
If so, date of most recent test:_____ Results: ___ Normal ___ Abnormal

12. What was your weight one year ago? _____ Five years ago? _____ At age 20? _____

13. Do you follow any special diet at the present time? ___ Yes ___ No
If so, what type?
___ Low Cholesterol/Low Fat ___ Low Salt ___ Reduced Calorie
___ Liquid Diet ___ Other
If Other, please specify: _____

14. What are your personal exercise program goals?
___ Weight Control/Loss ___ Staying in Shape ___ Increasing Strength
___ Stress Reduction ___ Cardiovascular Conditioning ___ Other
If Other, please specify:_____

15. Which days and times are best for you?

	Day	Time
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____
Saturday	_____	_____

16. What equipment do you presently have? _____
_____

17. Any additional information or comments before beginning your exercise program?
_____
_____
_____

18. T-shirt Size? SM _____ MED _____ LG _____ X-LG _____ XX-LG _____