MEDICAL / HISTORY QUESTIONAIRE

Please provide a complete response to all the questions listed below. This document along with your fitness assessment test will assist our nationally certified trainers in creating a customized workout program for you. It will allow our trainers to identify any strengths, weakness, and/or previous injuries which may impact your training program.

NAME: ____ DATE: ____________________

ADDRESS: ________________________________ CITY ____________________ STATE_______

HOME PHONE (____) _____________________ CELL (_____) ___________________________

AGE: ______ BIRTHDATE: _________________ OCCUPATION: ___________________________

PHYSICIAN'S NAME: _______________________________PHONE: (_____) ________________

EMERGEINCY CONTACT: ____________________________PHONE: (_____)________________

1. Are you presently involved in a regular exercise program? ☐ Yes ☐ No If yes, please list activity, duration, frequency and intensity: ____

____

2. Are you now or have you ever been on a diet? ☐ Yes ☐ No If yes, please explain

Type: ____________________________________ How Long __________________________

Results: ____

3. Do you consider yourself over weight☐? under weight ☐ ? If so, by how much? ________

4.. Do you consider yourself?

Sedentary ☐ Lightly Active ☐ Moderately Active ☐ Highly Active ☐

If you checked sedentary, please explain further. ___________________________________

5. Please characterize your lifestyle?

Highly Stressful ☐ Moderately Stressful ☐ Not Very Stressful ☐

If you checked highly stressful, please explain further. ________________________________

6. What is your favorite exercise? ____

7. What is your least favorite exercise? ____

8. Describe your greatest fitness accomplishment?______________________________________

____

9. Describe your biggest fitness roadblock?____

____

10. What is your current fitness goal?____

____

11. Tell us something about yourself that others would be surprised to know about you?

____

12. Do you know how to ride a bicycle? ☐ Yes ☐ No

13. Do you know how to swim? ☐ Yes ☐ No

14. How many meals do you usually eat per day? _______

15. Do you each snacks? ☐ Yes ☐ No, If yes, what type and what time of day?

____

16. Do you drink caffeinated coffee or colas? ☐ Yes ☐ No Number per day ____________

17. How many glasses of water do you drink during the day? ____________________________

18. Do you eat breakfast? ☐ Yes ☐ No

19. How many times per week do you usually eat the following foods? Beef _____

Fish _____ Pork _____ Fowl _____ Fried Foods _____ Fast Foods _____ Desserts _____

20. Do you regularly use any of the following? (check all that apply)

Butter _____ Sugar _____ Sweeteners _____ Salt _____ Whole Milk _____

21. Please list all the foods, snacks and drinks you have during a typical day. This profile will help us determine what recommendations we can make to you to help you optimize your nutrition program relative to your exercise and lifestyle habits. Please list in detail all the foods and condiments and the time of day for each meal/snack.

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

22. What is your favorite healthy food?____

23. What is your favorite cheat food?____

24. What is your most challenging nutritional habit that you would like to change?

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25. Please list five healthy and unhealthy foods that you eat or cook with?

HEALTHY	**UNHEALTHY**
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

26.. Do you now or have you ever smoked? ☐ Yes ☐ No

If you previously smoked: _____ number of packs per day _____ number of years.

If you currently smoke: ______ number of packs per day _____ number of years.

27.. Do you use alcohol? ☐ Yes ☐ No

If yes, number of drinks per day ______ per week ________? What type? _______________

28. Please list all prescription, over the counter medications and/or supplements you are currently taking.

____

____

____

28. Are you allergic to any medications? ☐ Yes ☐ No. If yes, please list below:

____

____

____

29. Do you now or have you ever had the following? **C** = **Current**, **P** = **Past**

☐ C ☐ P Heart attack, coronary bypass or other cardiac surgery
☐ C ☐ P Diabetes
☐ C ☐ P Stroke
☐ C ☐ P Peripheral vascular disease
☐ C ☐ P Phlebitis, emboli
☐ C ☐ P Rheumatic fever
☐ C ☐ P High blood pressure
☐ C ☐ P Low blood pressure
☐ C ☐ P Chest discomfort
☐ C ☐ P Extra, skipped or rapid heart beats/palpitations
☐ C ☐ P Heart murmurs
☐ C ☐ P Ankle swelling
☐ C ☐ P Cold hands or feet
☐ C ☐ P Shortness of breath
☐ C ☐ P Lightheadedness or fainting

- ☐ C ☐ P Epilepsy, seizures
- ☐ C ☐ P Anemia
- ☐ C ☐ P Asthma
- ☐ C ☐ P Bronchitis
- ☐ C ☐ P Chronic recurrent cough
- ☐ C ☐ P Trouble sleeping
- ☐ C ☐ P Migraine or recurrent headaches
- ☐ C ☐ P Swollen, stiff or painful joints
- ☐ C ☐ P Foot problems
- ☐ C ☐ P Knee problems
- ☐ C ☐ P Back problems
- ☐ C ☐ P Shoulder problems
- ☐ C ☐ P Neck problems
- ☐ C ☐ P Broken bones
- ☐ C ☐ P Ulcers
- ☐ C ☐ P Stomach or intestinal problems
- ☐ C ☐ P Hernia
- ☐ C ☐ P Limited range of motion in joints
- ☐ C ☐ P Arthritis
- ☐ C ☐ P Bursitis

If you checked **ANY** of the items on the medical history questionnaire, please explain below in detail.

____

____

____

____

What is your shirt size? ____ XS ____ S ____ M ____ L ____XL ____ XXL ____XXL

What is your shoe size? ________