DWH File

HEALTH AND FITNESS QUESTIONNAIRE FOR PERSONAL TRAINING

Name (first, last): _____

Date: _____ Age: _____ Email Address: _____

Sex: Female or Male Date of Birth: _____

Weight: (in pounds) _____ Height: _____

Phone# (____) _____ Work (___) _____

Address: _____

Physician's Name: _____

Physician's Phone# _____

Person to Contact in Case of Emergency Name: _____

Relationship _____ Phone# _____

Are you taking any medications or drugs? If so, what?

_____
_____

If needed, does your physician know you are participating in this exercise program?

_____

Describe your exercise program now.

_____
_____
_____

Describe your daily food and liquid consumption for a typical day: (Morning, Noon, Night, Snacks)

_____
_____
_____
_____

Do you now, or have you had in the past 5 years:

1. History of heart problems, chest pain or stroke.	Yes or No
2. Increased blood pressure.	Yes or No
3. Any chronic illness or condition.	Yes or No
4. Difficulty with physical exercise.	Yes or No
5. Advice from physician not to exercise.	Yes or No

6. Recent surgery (last 12 months).	Yes or No
7. Pregnancy (now or within last 3 months).	Yes or No
8. History of breathing or lung problems.	Yes or No
9. Muscle, joint, or back disorder, or any previous injury still affecting you.	Yes or No
10. Diabetes or thyroid condition.	Yes or No
11. Cigarette smoking habit. (If so, # packs per/ day)	Yes or No _____ #_____
12. Obesity (more than 20% over ideal body weight).	Yes or No
13. Increased blood cholesterol.	Yes or No
14. History of heart problems in immediate family.	Yes or No
15. Hernia, or any condition that may be aggravated by lifting weights.	Yes or No
16. Rapid or runaway heartbeat.	Yes or No
17. Skipped heartbeat.	Yes or No
18. Rheumatic fever.	Yes or No
19. Has your doctor ever said your blood pressure was too high?	Yes or No
20. Shortness of breath w/ or w/out exercise	Yes or No
21. Phlebitis or embolism.	Yes or No
22. Stroke.	Yes or No
23. Do you frequently have pains in your heart and chest?	Yes or No
24. Has your physician ever said you have heart trouble?	Yes or No
25. Do you often feel faint or have spells of severe dizziness?	Yes or No
26. Are you over age 65 and not accustomed to vigorous exercise?	Yes or No
27. Are you unaccustomed to vigorous exercise?	Yes or No
28. 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 or No
29. Recent hospitalization for any cause. List Specifics: _____	Yes or No
30. Orthopedic problems (including arthritis). List specifics:_____	Yes or No

Please explain any question answered 'yes' listed above.

_____
_____
_____
_____
_____
_____

What types of exercise interest you?

Walking _____ Jogging _____ Swimming _____ Cycling _____ Dance Exercise _____ Strength Training _____ Stationary Biking _____ Racquetball _____ Tennis ____

Others _____

What are your goals pertaining to physical fitness?

_____
_____
_____
_____

If applicable, in your opinion, what did your past personal trainer(s) do right and wrong?

_____
_____
_____

What is your primary objective in hiring a personal trainer or participating in boot camp?

_____
_____
_____

What days and times do you prefer to exercise (PERSONAL TRAINING ONLY)?

_____
_____

What obstacles do you face in achieving your fitness goals? Please include all realms of life (physical, mental, emotional, and social, etc.).

_____
_____
_____

Do your friends, family, and/or significant other support your decision to attain your physical fitness goals?

_____
_____
_____

If needed, are your ready for a lifestyle change? Why?

_____

_____

Additional Notes: