

PERSONAL TRAINING ASSESSMENT HEALTH HISTORY

CLIENT NAME:		TRAINER NAME:	
AGE:	D.O.B. / /	SEX: (M / F)	DATE:
CLIENT PHONE NUMBER:		CLIENT EMAIL:	

This form is designed as a self-help questionnaire. Many health benefits are associated with regular exercise which is why the American College of Sports Medicine recommends that every adult should accumulate at least 30 minutes of exercise on most, if not all, days of the week. For most people exercise should not pose a problem or hazard.

This form is designed to identify individuals for whom exercise might be a risk or those who should have a medical evaluation prior to beginning an exercise program.

MEDICAL HISTORY: Please check any and all that apply to you either currently or any time in your past.

Coronary Artery Disease, previous MI or revascularization procedure	Hypertension
Hypercholesterolemia (Total cholesterol >200/ HDL<40/ LDL>160)	Smoker (How much:_____)
Diabetes (Type I or Type II?_____)	Thyroid Problems
Blood Disorders (Anemia, clots, or excessive bleeding)	Stroke or TIA
Cancer (Type_____)	Known Heart Murmur
Arthritis or other Rheumatologic Disorders	Palpitations or Tachycardia
Taking Beta-blockers or Calcium-channel blockers	Dizziness
Eating Disorders (Anorexia, Bulimia, etc.)	Ankle Edema
Unexplained Weight Loss	Pain or Pressure in Chest with Exercise
Drastic, Unexplained Weight Gain	Unusual Pain with Exercise
Lung Disease (Emphysema, Asthma, or Bronchitis)	Fatigue with Activities
Joint or Muscle Pain at Rest	Shortness of Breath at Rest
List any Surgeries:	
Other:	

MEDICATIONS: Please list all medications (including over-the-counter and "herbal" medications) with dose:

ALLERGIES TO MEDICATIONS:

FAMILY MEDICAL HISTORY: (Particularly parents, siblings, and grandparents--strokes, heart disease, high cholesterol, etc.)

DO YOU HAVE ANY PHYSICAL COMPLAINTS TODAY?:

SOCIAL HISTORY

Married: (Spouse: _____) Emergency contact: () -
Children: (Ages: _____)
Occupation: (Description: _____)
Does your occupation require extended periods of sitting or repetitive movements? (_____)

EMOTIONAL HISTORY

What is your current stress level on most days?	None	Light	Moderate	Heavy
Do you ever feel depressed?	Never	Rarely	Occasionally	Often
Do you ever feel anxious?	Never	Rarely	Occasionally	Often
Do you have any physical problems/symptoms that you think are related to your emotions?	Yes		No	
What coping mechanisms do you have for stress?				
How much sleep do you get per night on average?				

EXERCISE HISTORY

Sedentary (little activity, no exercise)	Light Activity (desk job, exercise 1-2x/week)
Moderately Active (up and down a lot, exercise ~3x/week)	Very Active (Vigorous work, exercise 4-7x/week)
How long has it been since you regularly exercised?	
How often do you exercise?	
How long are you exercise bouts?	
What types of exercise are you currently doing or have you done in the past?	
Do you have any medical concerns/physical limitations about exercising?	
Do you have access to a gym at work or equipment at home?	
What type of equipment?	

NUTRITION HISTORY

How do you think your overall nutrition is?		
What is your daily water intake?	Do you drink alcohol? (How much/how often?)	Do you drink caffeinated beverages? (How much/how often?)
How many fruits per day?	How many vegetables per day?	How much dairy per day?
How many grains per day?	How many fats/sugars per day?	How much protein per day?
What do you think your nutrition weakness is?		

HEALTH AND WELLNESS GOALS

Improve overall fitness	Improve strength	Improve flexibility
Decrease stress level	Loose Weight	Improve cardiopulmonary endurance
Reduce risk of disease	Train for a specific sport or event	Other: