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Personal Training Health Screening Questionnaire

Personal Information
Today's date:_____
Title: O DR. O Mr. O Mrs. O Ms.
Name: _____ _____ Birth date: _____
Age: _____
Address: _____ Phone: (Home) _____
City: _____ Phone: (Work _____
Email: _____ Phone: (Cell) _____
Occupation:_____
Gender: Male_____ Female_____ Height: _____ Weight: _____
Person to contact in case of emergency: _____Tel:_____
Physician's Name: _____Tel: _____

Medical History
Please indicate if any of these statements apply to you by placing YES in the space provided (* past or current):
1. History of heart problem (i.e. Chest pain, heart murmur, or stroke) _____
2. Diabetes Mellitus _____
3. Asthma, breathing, or lung problems _____
4. Allergies _____
5. Cancer (other than skin) _____
6. Seizures, seizure medication, neurological problems, dizziness _____
7. High blood pressure _____
8. Back problems, joint or muscle disorder still affecting you _____
9. Recent surgery (last 12 months) _____
10. Hernia or any condition that may be aggravated by exercise _____
11. Physician's advice not to exercise _____
12. History of high cholesterol _____
13. Family history of coronary heart disease? _____
14. Do you smoke tobacco products _____
15. Do you consume alcohol? _____
16. Do you take supplements of any kind? _____
17. Are you on medication? _____
18. Do you have joint problems that might be aggravated by exercise? _____
19. Is stress from daily living an issue in your life? _____

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Skeletal Injuries
Back_____
Neck_____
Head_____
Knee(R, L) _____
Shoulder(R, L) _____
Other injuries: _____
Surgery: _____
Please describe any special considerations or how your injury currently affects your ability to function: (i.e. Illness or Injury)
_____
_____

Please talk with your doctor by phone or in person before you start any new training program or have a fitness assessment. Tell your doctor about your health questionnaire and which questions you answered yes.

Goals

1. When it comes to exercise, what are your personal goals?
_____
_____
_____

2. Why do you want to achieve these goals?
_____
_____
_____

3. What aspects of exercise/ movement do you think you need to concentrate on?
_____
_____
_____

4. What kind of exercise/movement do you enjoy doing and why?
_____
_____
_____

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Fitness History

1. Are you physically active besides conventional exercise (walking 30 minutes 2 or more times a week)?

_____

2.Do you exercise regularly (2 or more times a week)?

_____

3. Please describe your weekly exercise routine including duration and type of training.

_____
_____
_____

4. How long has it been since you have exercised regularly? (2 or more times/week).

_____

5. Do you have experience with free weights, Pilates, or yoga?

_____

6. What type of cardiovascular exercise are you familiar with?

_____

7. If you are an experienced exerciser or athlete, what specifically do you have experience doing?

_____

_____

8. Are there any exercises that are contraindicated or not recommended by your physician or physical therapist?

_____

9. How many hours a day do you sit?_____

10. Please indicate your daily stress level (low-1, high=5) please circle one.
Physical 1 2 3 4 5
Personal/ Emotional 1 2 3 4 5
Mental/Career 1 2 3 4 5

11. What is your present method of handling stress:

_____
_____

12. How many hours of sleep do you get per night?_____

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13. What is your available time and frequency for exercise?
What days: M T W TH F
What times: AM_____ PM_____

14. Any special considerations or requests?
_____

15. How did you find StretchWorks?_____