Health History & Fitness Behavior Questionnaire

Name: _____ **Today's Date:** _____

Age: _____ **Gender: M F**

Phone:

Email: _____ **How would you prefer to be contacted?** _____

Emergency Contact: Name:_____ **Relationship:** _____ **Phone:** _____

Part 1 – Known Diseases (Medical Conditions)

1. List the medications you take on a regular basis and describe their purpose.

2. Do you have diabetes?	No	Yes
a) If yes, please circle if it is insulin dependent diabetes mellitus (IDDM) or non-insulin dependent diabetes mellitus (NIDDM).	IDDM	NIDDM
b) How many years have you had diabetes?	_____ years	
3. Have you had a stroke?	No	Yes
4. Has your doctor ever said you have heart trouble?	No	Yes
5. Do you have asthma?	No	Yes
a) If yes to #5, do you take asthma medication?	No	Yes
6. Are you, or do you have reason to believe, you may be pregnant?	No	Yes
a) If yes to #6, when is your due date?	_____ due date	
7. Is there any other physical reason that prevents you from participating in an exercise program, (e.g., cancer, osteoporosis, severe arthritis, mental illness, thyroid, kidney, or liver disease)? Please list: _____	No	Yes

_____

Part 2 – Signs and Symptoms

8. Do you often have pains in your heart, chest, neck, jaw, arms or surrounding areas, especially during exercise?	No	Yes
9. Do you experience unusual fatigue or shortness of breath **at rest** or with **mild exertion**?	No	Yes
10. Do you often feel faint or have spells of severe dizziness during exercise?	No	Yes
11. Have you been awakened **at night** by an attack of shortness of breath?	No	Yes
12. Do you experience swelling or accumulation of fluid in or around your ankles?	No	Yes
13. Do you often get the feeling that your heart is beating faster, racing, or skipping beats, either at rest or during exercise?	No	Yes
14. Do you regularly get pains in your calves and lower legs during exercise, which are not due to soreness or stiffness?	No	Yes
15. Has your doctor ever told you that you have a heart murmur?	No	Yes
16. Have you had an attack of shortness of breath that came on **after you stopped exercising**?	No	Yes

Part 3 – Cardiac Risk Factors

17. Has your father, mother, brother, or sister had a heart attack or suffered from a cardiovascular disease before the age of 55 (male) or 65 (female)? No Yes
    If yes,
    a) Was the relative male or female? _____
    b) At what age did he or she suffer the stroke or heart attack? _____
    c) Did this person die suddenly as a result of the stroke or heart attack? _____
18. Do you smoke cigarettes on a daily basis, or have you quit smoking within the past 6 months? No Yes
    a) If yes to #17, about how many cigarettes do you smoke per day? _____cigs/day
19. Has your doctor ever told you that you have high blood pressure? No Yes
    a) If yes to #18, are you on any antihypertensive medication? No Yes
20. Please indicate the following values if known:
    a) Blood Pressure _____ / ____ mmHg
    b) Total serum cholesterol _____ mg/dl
    c) HDL cholesterol _____ mg/dl
    d) LDL cholesterol _____ mg/dl
    e) Fasting Blood Glucose level _____ mg/dl
    f) Please indicate when you had these values measured? _____ /_____ mo / yr
21. Please indicate the following information as accurately as possible. Your personal trainer is available to measure these values.
    a) Height _____ in or cm
    b) Weight _____ lbs or kg
    c) Waist circumference _____ in or cm
    d) Resting Heart Rate _____ bpm

Part 4 – Exercise Intentions & Current Exercise Behavior

22. Do you participate in a regular exercise program, or accumulate 30 minutes or more of moderate physical activity at least 5 days per week? Yes No
23. Do you want to exercise at a moderate intensity (e.g., brisk walking) or at a vigorous intensity (e.g., jogging)? Moderate Vigorous
24. What is your occupation? _____

    How physical is your work (circle one)? Mostly sitting Light work Moderate work Vigorous
25. Do you currently engage in regular **aerobic/cardio** activities such as fitness walking, jogging, swimming, cardio equipment, aerobics classes or videos, etc? If yes: Yes No
    a) Specify type(s) of activities? _____
    b) Frequency: _____ exercise sessions per week
    c) Intensity: Light Moderate Vigorous
    d) Duration: _____ minutes per session
    e) How long have you been doing cardio **regularly?** _____
26. Do you currently participate in **resistance training** on a regular basis? If yes, describe your current resistance training routine (include frequency, duration, sets and reps, etc.): _____ Yes No
27. Do you currently practice regular **flexibility** training? If yes, describe what you do and how often: Yes No

Part 5—Other Health Issues

28. Do you have any bone or joint problems that need to be considered in developing an appropriate workout plan? List any injuries which **currently** bother you (e.g., sprains, muscle pulls, bursitis, tendonitis, broken bones, etc.). Please note the specific location of these injuries.

29. Do you have any other medical condition or physical reason not mentioned earlier that might need special attention in an exercise program (e.g., fibromyalgia, hemophilia, seizures, eating disorder, etc.). If yes, please describe below.

Part 6—Preferences and Interests Related to Health & Fitness

30. What is your main motivation in seeking professional assistance?

31. What are your specific fitness goals (Indicate all that apply)?

___ Establish Exercise habit ___ Sports conditioning: _____

___ Improve cardiovascular fitness ___ Injury Rehabilitation _____

___ Increase strength and endurance ___ Improve muscle tone

___ Improve flexibility ___ Increase muscle mass

___ Train for a triathlon ___ Train for Cycle Oregon, STP, etc.

___ Train for running event, i.e. 5k, 10k, marathon

___ Other: _____

32. What are your specific health goals (indicate all that apply)?

___ Improve energy level ___ Control cholesterol ___ Improve nutrition

___ Control blood pressure ___ Feel better overall ___ Stop smoking

___ Achieve balance in my life ___ Reduce stress ___ Reduce body fat

___ Prevent or control diabetes Other: _____

33. If you are interested in weight loss, please answer the following questions::

a) What do you think is a realistic expectation for weight loss? _____ lb/wk

b) Are you interested in having your body composition assessed (i.e., height, weight, circumferences, skinfold measures)? Yes No

34. What type(s) of aerobic activities do you prefer (check all that apply)?

___ Walking outdoors ___ Jogging outdoors ___ Treadmill

___ Elliptical or Cross-trainer ___ Stair stepper ___ Step Mill

___ Rowing machine ___ Recumbent bike ___ Spinning bike

___ Cycling outdoors ___ Water exercise ___ Swimming laps

___ Exercise videos ___ Fitness classes Other:_____

35. What type of resistance training do you prefer (check all that apply)?

___ Free weights ___ Dumbbells ___ Dynabands

___ Weight machines ___ Bowflex ___ Stability ball

___ Body weight ___ Exercise videos ___ Pilates

___ Other (specify): _____

36. Do you currently participate in any recreational or competitive sports? Yes No

___ Golf ___ Soccer ___ Basketball

___ Bowling ___ Volleyball ___ Swimming

___ Cycling ___ Running ___ Racquet sports

___ Other (please specify): _____

37. Do you prefer to workout alone, with a partner, or in a group? _____

38. Are there activities that you do not like and would like to avoid?

39. What barriers have you experienced in the past that have kept you from exercising regularly? Explain.

40. Would you like to do the same activities regularly, or would you prefer variety in your workout schedule?

41. In the chart below, please indicate the time of day and length of time you plan to workout on any given day.

	Mon	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Indicate time of day you will workout							
Indicate length of time you have available.							

I have read, understood, and completed this questionnaire and attest that it is truthful and complete to the best of my knowledge. I understand that this information will be kept confidential and will only be used to further my health and safety. I also understand that a physical exam may be necessary prior to beginning a health and fitness program. I agree to provide any documentation from my health provider indicating that it is safe for me to participate in an exercise program and provide any limitations that s/he feels may be necessary.

Signature:_____ Date:_____

This form has been adapted from: *ACSM's Guidelines for Exercise Testing and Prescription 6th Edition* (2000). Lippincott, Williams, & Wilkins Publisher. *ACSM's Health-Related Physical Fitness Assessment Manual (2005).* Lippincott, Williams & Wilkins Publisher. Olds, Tim & Norton, Kevin, *Pre-Exercise Health Screening Guide* (1999). Human Kinetics PublisherAcevedo, E.O. & Starks, M.A. *Exercise Testing and Prescription Lab Manual* (2003). Human Kinetics Publisher.