ADMIN USE ONLY: (rev. 3/15)		
Referred or brought in by: _____		
Inf. Consent signed	Y	N
Turned in to office:	Y	N
EZ Facility:	Y	N
IContact:	Y	N

HEALTH HISTORY and LIFESTYLE QUESTIONNAIRE

SECTION I (General Information)

Name: _____ Date: _____ Email: _____

Birth Date: (mm/dd/yy) _____Age: _____ Height: _____ Weight: _____

Street Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Primary Physician: _____ Phone: _____ Referred by: _____

In case of an emergency notify the following person(s):

Name:_____ Address:_____

Phone: (H)_____ (W):_____

SECTION II

Describe your primary reason for coming to us. If you primary reason include symptoms, please describe _____

_____

Do you have any functional limitations in your daily routine, work or recreational activities? If yes, describe: _____

_____

List your goals for training: 1. _____ 2. _____

_____ 3._____

If you have physical discomfort, pain or injury, please complete the following section. Circle words that best describe your symptoms:

Sharp	(or)	Ache
Tingling	(or)	Numb
Localized	(or)	Radiating
Constant	(or)	Variable
Pain	(or)	Stiffness

Please fill in all that are appropriate:

1. Where does it hurt? _____

2. Date symptoms first appeared: _____
3. Date of Injury: _____
4. Positions/activities that aggravate your symptoms: _____
5. Positions/activities that relieve your symptoms: _____
6. Time of day when symptoms are most apparent: _____

SECTION III (Medical Care)

When was your last physical exam?

_____

Check each applicable box for conditions you currently have (C) or have had in the past (P):

C	P		C	P		C	P	
☐	☐	anemia	☐	☐	depression	☐	☐	gout
☐	☐	arthritis	☐	☐	eating disorder	☐	☐	hemophilia
☐	☐	bursitis	☐	☐	epilepsy		☐	☐ HIV
☐	☐	cancer	☐	☐	fibromyalgia	☐	☐	hypoglycemia
☐	☐	cirrhosis	☐	☐	foot problems	☐	☐	lupus/other autoimmune
☐	☐	chronic fatigue	☐	☐	glaucoma			

If you have checked any of the above conditions, please describe below:

_____

_____

_____

1. Have any members of your immediate family (mother, father, sister or brother) been diagnosed with cardiovascular disease? ___ Yes ___ No
2. Have you ever been diagnosed with cardiovascular disease? ___ Yes ___ No
3. Do you ever experience an irregular or racing heart rate during exercise or at rest? ___ Yes ___ No
4. Do you or have you ever experienced chest pains? ___ Yes ___ No
5. Have you ever had a heart attack, coronary bypass, cardiac surgery, stroke? ___ Yes ___ No
6. Have you ever had an abnormal resting or stress EKG? ___ Yes ___ No
7. Do you have difficulty breathing or unusual shortness of breath? ___ Yes ___ No
8. Have you ever been diagnosed with pulmonary disease or pulmonary problems (asthma, emphysema, bronchitis)? ___ Yes ___ No
9. Have you ever experienced light-headedness or fainting? ___ Yes ___ No
10. Have you ever had or do you have high blood pressure? If yes, what is your blood pressure and is it controlled by medication? Please explain

    _____

    _____

11. Have you been diagnosed with Diabetes? If yes, what type and how is it being controlled?

_____

_____

SECTION IV (Medications)

List all medications you are currently taking:

Name	Frequency	For
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION V (Treatments)

List any hospitalizations, surgeries, physical therapy or chiropractic care:

Date	Age	Condition	Treatment	Outcome/Results
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List any other health related practitioners you are currently seeing:

Name	Frequency	For
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION VI (Lifestyle)

How do you spend most of your time at work?

_____ Sitting _____ Standing _____ Carrying loads _____ Driving _____ Walking

Do you smoke? _____

How many times per week do you engage in moderate or strenuous exercise for at least 30 minutes?

_____ 1 _____ 2 _____ 3 _____4 _____ 5 _____>5

Describe your energy level?

_____

PERSONAL TRAINING POLICIES

1. All clients will be charged for any training session(s) not cancelled 24 hours in advance. This excludes situations that are out of your control (i.e. weather, illness, etc.)
2. Payment for all training services should be paid per visit or on a weekly basis.
3. Clients should make all checks or payments to Training Partners, Inc.
4. Clients must complete all applicable form (informed consent, medical clearance, medical questionnaire, etc.) before training sessions can be initiated.

INFORMED CONSENT FORM

By signing this consent, I acknowledge that all information listed above is accurate and that I have voluntarily chosen to participate in a program of progressive physical exercise at Training Partners, Inc. Furthermore, I acknowledge being informed of the strenuous nature of the program and the potential for unusual, but possible, physiological results including but not limited to abnormal blood pressure, fainting, heart attack, or death. In addition, I assume all risk for my health and wellbeing and hold harmless of any responsibility, the instructor(s), facility (Training Partners, Inc.), trainer(s), or any person (s) involved with this program and testing procedures.

Client/Member Signature:_____ Date:_____