HEAVY METAL FITNESS

Date: _____

NEW CLIENT HEALTH & FITNESS QUESTIONNAIRE

Name: _____ Birthday: ____/____/____ Gender: _____

PERSONAL HEALTH HISTORY

What was the date of your most recent physical exam?	**Date:**	
Heart Disease:		
Do you have a history of coronary heart disease (including open heart surgery, heart attack, angioplasty, coronary stent, etc.)?	**Yes**	**No**
Do you experience pain, burning, discomfort, or tightness in the chest, arm, jaw, or neck at rest or during activity?	**Yes**	**No**
Do you have a pacemaker?	**Yes**	**No**
Have you had a cardiac stress test within the last 12 months?	**Yes**	**No**
Diabetes:		
Do you have diabetes?	**Yes**	**No**
If you have diabetes, when was your period of onset?	**Before Age 30**	**After Age 30**
How often do you check your blood sugar level?	**Per Day**	**Per Week**
Are you insulin dependent?	**Yes**	**No**
Do you have a history of hypoglycemia?	**Yes**	**No**
Blood Pressure:		
Do you currently have high blood pressure?	**Yes**	**No**
Are you using medication for high blood pressure?	**Yes**	**No**
Cholesterol:		
When was the last time you had your cholesterol checked?	**Date:**	
Please record your cholesterol results to the right.	**HDL:**	**LDL:**
	Triglycerides:	

PERSONAL HEALTH HISTORY, CONTINUED

Neurological:

Have you ever had a stroke? If yes, when?	Yes Date:	No
Do you ever experience unexplained dizziness or weakness while walking, standing, or seated? If yes, please explain.	Yes	No

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Orthopedic Concerns:

Do you have a history of any of the following…

Bone Fractures	Yes	No	Back, Spine or Neck Problems	Yes	No
Foot Problems	Yes	No	Ligament Sprains	Yes	No
Joint Pain	Yes	No	Tendonitis	Yes	No
Diagnosed Arthritis	Yes	No	Bodily Injury (please explain):		

Do you have any physical limitations regarding exercise? If yes, please explain in detail.	Yes	No

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Women's Health

Are you pregnant?	Yes	No
If yes, how far along are you and when is your due date?	# of Weeks: Due Date:	
Are you currently on a Hormone Replacement Therapy program? If so, have you experienced any side effects from usage? Please explain.	Yes	No

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Other Health Issues:

Do you have any other health conditions that have not been included? (asthma, osteoporosis, epilepsy, MS, Parkinson's disease, etc.) Please explain in detail.	Yes	No
Do you have any other reason to limit activity or refrain from exercise? Please explain in detail.	Yes	No

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Weight:

What is the most you have ever weighed (excluding pregnancy)?	LBS:	
Have you lost or gained a lot of weight in the last 5 years?	Yes	No
At what weight do you feel "your best?"	LBS:	
How tall are you?	Height:	

MEDICATIONS

Please list all current medications and why you take them, including over-the-counter drugs consistently used, nutritional supplements for weight loss or athletic performance, and any side effects.

Medication: **Use:** **Side Effects:**

FAMILY HISTORY

If any relatives (parents, grandparents, siblings) have had any of the following medical conditions, please explain their relationship, age, and condition below.

Diabetes	Heart Disease	High / Low Blood Pressure	Stroke	High Cholesterol	Chest Pain
Asthma	Obesity	Epilepsy	Osteoporosis	Arthritis	Cancer

NUTRITION

How many meals do you eat each day?	#:	
Do you count calories or restrict cholesterol, fat, & sodium in your diet?	Yes	No
Do you know how to read nutrition facts labels on food products?	Yes	No

SMOKING & ALCOHOL

Do you smoke?	Yes	No
Are you a former smoker? If so, when did you quit smoking?	Yes Date:	No
Do you drink alcohol on a regular basis?	Yes	No

LIFESTYLE

What kinds of hobbies & extracurricular activities do you enjoy?

Does your job involve physical activity? Please circle one:

Inactive (Desk Job) – Light Work (Housekeeping) – Heavy Work (Carpentry, Lifting)

FITNESS & EXERCISE

Exercise History:

How many days per week do you exercise?

Please list all types of exercise you currently perform. Include all forms of cardiovascular, flexibility, and strength training.

What do you LIKE and DISLIKE about the exercises you are doing (or have done in the past)?

How do you feel about exercise? Please circle one:

_____ I dislike it
_____ It's good for my health
_____ It makes me feel good
_____ It's OK
_____ Takes too much time
____ A necessary evil
_____ I love it!
_____ My doctor told me to
_____ I need help

Fitness Goals, Motivation & Support:

What are your fitness goals? Mark the goals most important to you:

_____ Increase Muscle Strength
_____ Improve Flexibility
_____ Improve Cardiorespiratory Fitness
_____ Gain Weight (Muscle Mass)
_____ Post-Rehabilitation Training
_____ General Health & Fitness
_____ Reduce Body Fat Percentage
_____ Lower Blood Pressure
_____ Regular Exercise Program
_____ Reduce Stress & Tension
_____ Improve Athletic Performance
_____ Lower Body Weight

Which phrase best describes your motivation levels?

_____ I am self-motivated
_____ I need constant motivation
_____ I usually have some problems staying motivated
_____ Exercise is easier if I have a partner
_____ Exercise is easier when I have regularly scheduled appointments

Who is supportive of you achieving your goals? Family, Friends, Work Colleagues…

What kinds of support do you respond to best?

ADDITIONAL INPUT

Please list any specific questions, concerns, and ideas you would like to discuss with your trainer.