Folsom Wellness & Sports Conditioning Center
Health/Medical History Questionnaire

This information is used solely as an aid. It will not be released without your knowledge and consent.

Name_____Date_____ Birth date_____

Address_____
Street City State Zip

Phone Number:_____Email_____

Personal Physician:

Name:_____ Phone:_____

Personal Training Par-Q(Physical Activity Readiness Questionnaire)

YES	NO	
☐	☐	**1.** Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
☐	☐	**2.** Do you feel pain in your chest when you do physical activity?
☐	☐	**3.** In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	**4.** Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	**5.** Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by change in your physical activity?
☐	☐	**6.** Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

If you checked "yes" for any question #1-#6, the "National Strength and Conditioning Association" states that you must receive clearance from your physician prior to participating in a progressive resistance exercise program.

I have read this entire document and have answered all of the questions to the best of my knowledge.

_____ _____
Last Name, First Name (print) Signature

_____
Date

Medical History

Present & Past History

Have you had or do you presently have any of the following conditions? (Check if *yes*.)

__ Rheumatic fever

__ Recent operation

__ Edema (swelling or ankles)

__ High blood pressure

__ Injury to back or knees

__ Low blood pressure

__ Seizures

__ Lung disease

__ Heat attack

__ Fainting or dizziness

__ Diabetes

__ High cholesterol

__ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night)

__ Shortness of breath at rest or with mild exertion

__ Chest pains

__ Palpitations or tachycardia (unusually strong or rapid heartbeat)

__ Intermittent claudication (calf cramping)

__ Pain, discomfort in the chest, neck jaw, arms, or other areas

__ Known heart murmur

__ Unusual fatigue or shortness of breath with usual activities

__ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg

__ Other

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

__ Heart attack

__ Heat operation

__ Congenital heart disease

__ High blood pressure

__ High cholesterol

__ Diabetes

__ Other major illness_____

Explain checked items:

_____

_____

_____

Activity History

1. How were your referred to this program? (Please be specific.)

_____

2. Why are you enrolling in this program? (Please be specific.)

_____

3. Are you presently employed? Yes__ No__

4. What is your present occupational position?

_____

5. Name of company:

_____

6. Have you ever worked with a personal trainer before? Yes__ No__

7. Date of you last physical examination preformed by a physician:

_____

8. Do you participate in a regular exercise program at this time? Yes__ No__ \

ACTIVITY FREQUENCY TIME

9. Can you currently walk 4 miles briskly without fatigue? Yes__ No__

10. Have you ever performed resistance training exercises in the past? Yes__ No__

11. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes__ No__

If yes, briefly describe: _____

12. Do you smoke? Yes__ No__

If yes, how much per day and what was your age when you started?

Amount per day_____ Age_____

13. How high is the level of stress in your life? HIGH MODERATE LOW

14. What is your body weight now? ___ What was it one year ago?___ At age 21___

15. Do you consider yourself:

1) At my goal weight/body composition for maintenance

2) At a weight lower than optimal for health and fitness

3) At a weight higher than optimal for health and fitness

16. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits?_____

_____

_____

17. List the medications, nutritional supplements(s)/herbs, etc. you are presently taking.

Medication, supplement or herb Dosage Frequency

18. Please list restaurants where you frequently eat and how often you eat out:

Who usually prepares food in your household?

Where do you typically shop for groceries?

19. List in order your personal health and fitness objectives.

a. _____

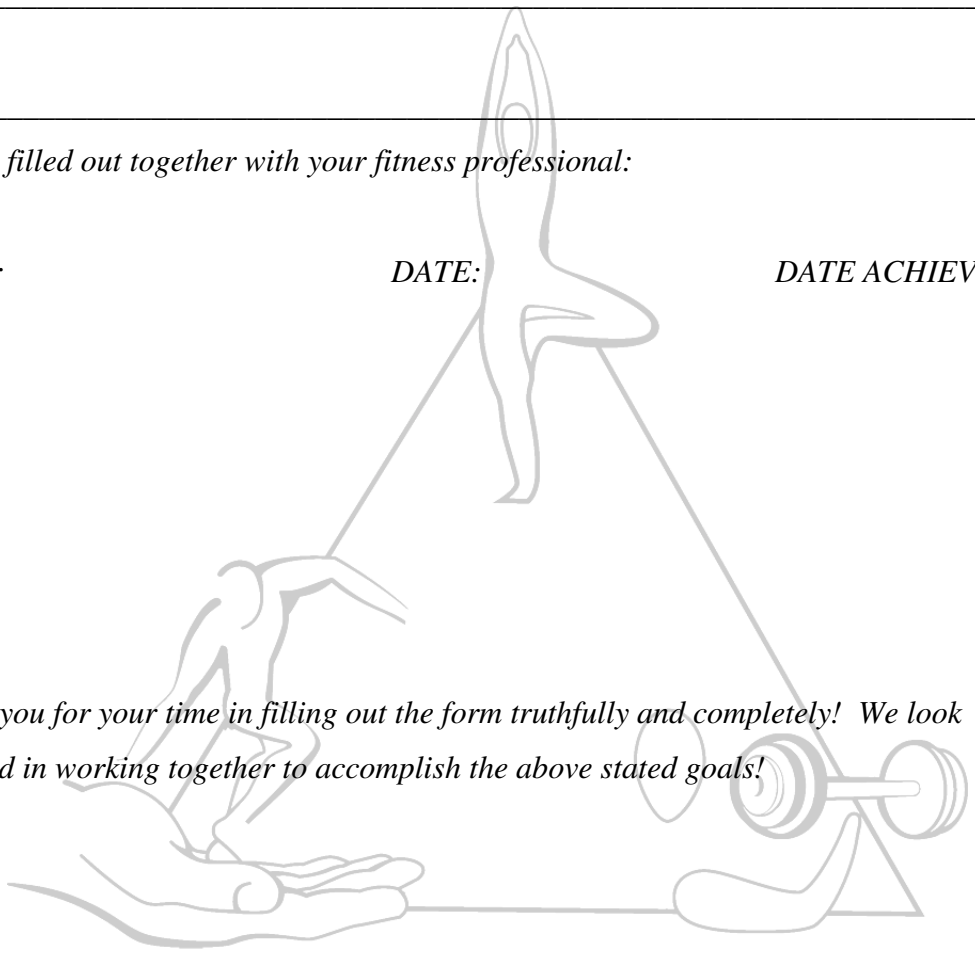
b. _____

c. _____

_____

**To be filled out together with your fitness professional:*

GOAL: *DATE:* *DATE ACHIEVED:*



Thank you for your time in filling out the form truthfully and completely! We look forward in working together to accomplish the above stated goals!

10/14/10