



Offering a Biblical approach to fitness

John 5:1-17

HEALTH AND MEDICAL QUESTIONNAIRE

Date: _____

Name: _____ Date of birth: _____ Age: _____

Address: _____

Street City State Zip

Phone (Cell): _____ (Home): _____ E-mail address: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone

(Cell): _____ (Home): _____

Primary Care Provider:

Name: _____ Health Care Facility: _____

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 of ankles)

___ High blood pressure

___ Injury to back or knees

___ Low blood pressure

___ Seizures

___ Lung disease

___ Heart attack

___ Fainting or dizziness with or without physical exertion

___ 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 with or without physical exertion

___ 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 of your body

___ Stroke

___ Eating Disorder

___ Bariatric Surgery

___ Other

Please list any surgeries that you've had (along with dates): _____

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 arrhythmia

___ Heart attack

___ Heart operation

___ Congenital heart disease

___ Premature death before age 50

___ Significant disability secondary to a heart condition

___ Marfan syndrome

___ High blood pressure

___ High cholesterol

___ Diabetes

___ Other major illness _____

Explain checked items: _____

Activity History

1. How were you 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 your last physical examination performed by a physician:

8. Do you participate in a regular exercise program at this time? Yes ____ No ____

If yes, briefly describe: _____

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. What is your body weight now? _____ What was it one year ago? _____

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

15. List the medications you are presently taking.

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

a.

b.

c.

From NSCA, 2012, NSCA's essentials of personal training, 2nd ed., J. Coburn and M. Malek (eds.), (Champaign, IL: Human Kinetics).