Health History Form

Name_____

Date _____ Age _____ Gender: Male Female *(circle one)*

Phone _____ Email Address _____

Person to contact in case of an emergency:

Name _____ Relationship _____

Phone _____ Alternate Phone _____

Exercise Habits

1. In the past 6 months, how often have you engaged in physical activity? *(circle one below)*
    a. Always (7 days a week)
    b. Regularly (3–4x/week)
    c. Semi regularly (1–2x/week)
    d. Sporadically (1–2x/month)

2. Please explain your current exercise regime or activities performed in the past:

_____

3. Please list any cardio vascular activities that you enjoy:

_____

4. Please list any strength training exercises that you enjoy:

_____

5. What are your personal barriers for exercising or sticking to a program?

_____

6. How much time do you plan spending on your workout program? ____ Min/day ____ Days/wk

Exercise Goals

1. Why have you decided to begin or improve your exercise program?

_____

2. Why have you decided to come to class?

_____

3. Specifically describe what you would like to accomplish in your workout sessions.

_____

4. Specifically describe what you would like to accomplish through your fitness program during the next:
    a. 1 Month: _____
    b. 6 Months: _____
    c. 1 Year: _____

LOVE GOD. GET HEALTHY. BE WHOLE. LOVE OTHERS.

Personal History

In order to design a safe and effective fitness program, it is important that you complete the following Health History. It is crucial that you answer all the questions honestly and to the best of your ability. Please be advised that all information is kept strictly confidential.

Check the appropriate response. Read all the questions thoroughly.	**YES**	**NO**
1. Has your doctor ever told you that you have heart problems?	____	____
2. Has your doctor ever told you that you have high blood pressure?	____	____
3. Have you ever had stroke or heart attack?	____	____
4. Have you ever had pain in your chest that concerned you?	____	____
5. Do you ever feel faint or have dizzy spells?	____	____
6. Have you had surgery in the last six months?	____	____

Check the appropriate condition(s) that apply to you below:

Diabetes _____ Epilepsy _____ Blood Pressure _____
Asthma _____ Arthritis _____ High Cholesterol _____
Heart _____ Pregnancy _____ Osteoporosis _____

Have you injured or have chronic pain in the following areas?

Neck _____ Upper Back _____ Shoulders _____
Elbows _____ Lower Back _____ Hips _____
Wrists _____ Knees _____

If yes, please explain:

_____

_____

Are you currently taking any medications? Yes _____ No _____

If you checked yes, please list medications, dosage and for what condition.

Medication _____ Dosage _____ Condition _____
Medication _____ Dosage _____ Condition _____
Medication _____ Dosage _____ Condition _____

Please write any known reactions to exercise your medication can have on you.

_____

_____

Do you smoke? Yes _____ No _____
Do you use alcohol? Yes _____ Drinks/week _____ No _____

Are there any other reasons (health or personal) that may limit or prevent you from exercising?

*Please be advised that certain health restrictions may require you to obtain medical clearance from your physician before training can begin.

"I can do everything through him who gives me strength."
Philippians 4:13