

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History

 Yes No

 \_\_\_\_\_ \_\_\_\_\_\_ Do you feel pain in your chest when doing physical activity?

\_\_\_\_\_ \_\_\_\_\_\_ Have you had pain in the chest when NOT doing physical activity?

\_\_\_\_\_ \_\_\_\_\_\_ History of heart problems or stroke?

\_\_\_\_\_ \_\_\_\_\_\_ Elevated blood pressure?

\_\_\_\_\_ \_\_\_\_\_\_ Is your doctor currently prescribing medications for your blood pressure?

\_\_\_\_\_ \_\_\_\_\_\_ Elevated cholesterol level?

\_\_\_\_\_ \_\_\_\_\_\_Obesity (more than 20% over ideal body weight)?

\_\_\_\_\_ \_\_\_\_\_\_Any chronic illness or condition?

\_\_\_\_\_ \_\_\_\_\_\_Advice from a physician not to exercise?

\_\_\_\_\_ \_\_\_\_\_\_ Muscle, joint, or back disorder? Any previous injury?

\_\_\_\_\_ \_\_\_\_\_\_ Recent surgery (last 12 months)?

\_\_\_\_\_ \_\_\_\_\_\_Pregnancy (now or within three months)?

\_\_\_\_\_ \_\_\_\_\_\_ History of lung or breathing problems?

\_\_\_\_\_ \_\_\_\_\_\_ Diabetes or thyroid condition?

\_\_\_\_\_ \_\_\_\_\_\_Smoking habits?

\_\_\_\_\_ \_\_\_\_\_\_Difficulty with physical exercise?

Please explain any “Yes” answers bellow:

How Often would you characterize your stress level as being high?

\_\_\_\_\_ Occasionally \_\_\_\_\_\_Frequently \_\_\_\_\_ Constantly

Which do you eat regularly?

\_\_\_\_ Breakfast \_\_\_\_\_ Midmorning Snack \_\_\_\_ Lunch \_\_\_\_\_ Mid-afternoon \_\_\_\_ Diner \_\_\_\_\_ After-dinner snack

Do you take supplements on a regular basis? Please list them if you do

**Activity Questionnaire:**

Occupation

Do you currently maintain an endurance exercise programs?

What type of exercise do you do?

At what intensity level? (i.e. walk 2 miles in 30 min. or walk 3 mph at 4% grade)

How long?

How many times a week?

Do you strength train?

Do you have home exercise equipment?

What do you hope to gain from working with a trainer?

List any specific goal you would like to achieve through an exercise program.

What types of activities would you find enjoyable?

List any medications or supplements that might affect exercising:

List any current or previous injuries / conditions that might affect your exercise program: