BrittniCastillo

Personal Trainer-Womens weightloss-Nutrition

Health history Questionnaire

Please print your answers. Please print clearly.

Name: Date of Birth: Age:

Address:

City/ state/ zip:

Phone number: Occupation:

In case of emergency, please notify:

Name: Relationship:

Phone Number:

Physician Information

Current Physician: Phone Number:

Are you under the care of a physician, chiropractor, or other health care professional for any reason? (circle) If yes, list reason: YES NO

Are you taking any medications? (if yes, please list) YES NO
Medication: Dosage/ frequency: condition:

List any and all allergies:

Has your doctor ever diagnosed you with high blood pressure? YES NO

Has your doctor ever diagnosed you with a bone/ joint problem that has Been or could be made worse by exercise? YES NO

Are you over 65 years of age? YES NO

Are you used to vigorous exercise? YES NO

BrittniCastillo

Personal Trainer-Womens weightloss-Nutrition

Health history Questionnaire

Medical Information- Please answer the following questions (circle one):

1.Have you experienced any chest pain associated with either exercise or stress? YES NO (if yes, please explain)

2.Have you experienced shortness of breath with or without exercise? YES NO (if yes, please explain)

3.Have you experienced fainting or light headedness? YES NO (if yes, please explain)

4.Have you had any recent hospitalization for any reason? YES NO(if yes, please explain)

5.Do you have any orthopedic conditions (including arthritis)? YES NO(if yes, please explain)

6.Have you ever experienced a rapid heartbeat or palpitations? YES NO(if yes, please explain)

7.Is there any reason you should not follow a regular exercise program? YES NO(if yes, please explain)

Please indicate if a blood relative (parent, sibling, first cousin etc.) has a history of any of the following conditions. If there is family history for any condition, please check the box to the left. On the line to the right, please indicate who in the family has or had this condition.

- ☐ Asthma .....
- ☐ Respiratory/ pulmonary conditions .....
- ☐ Diabetes: type 1: type 2: How long? .....
- ☐ Epilepsy: Petite Mal: Grand Mal: other: .....
- ☐ Osteoporosis: .....
- ☐ Coronary artery disease: .....
- ☐ Heart attack: .....
- ☐ Hypertension: .....
- ☐ High blood pressure: .....
- ☐ Stroke: .....

BrittniCastillo

Personal Trainer-Womens weightloss-Nutrition

Health history Questionnaire

Lifestyle/ Habits- Please check the box that best describes your current habits.

1.Do you smoke? YES NO If yes, how often:

- ☐ Former user: Date quit:
- ☐ 2 or fewer cigarettes per day
- ☐ 5 to 10 per day
- ☐ More than 10 per day

2.Do you drink caffeine? YES NO if yes, how often:

- ☐ Several times a day
- ☐ Once per day
- ☐ Few times per week
- ☐ Few times per month

3.do you drink alcohol? YES NO if yes, how often:

- ☐ Several times a day
- ☐ Once per day
- ☐ Few times per week
- ☐ Few times per month

4.on average, how many hours of sleep do you get each night?

- ☐ More than 10 hours
- ☐ 8-10 hours
- ☐ 5-7 hours
- ☐ Less than 5 hours

5.on average, what is your energy level like each day?

- ☐ High energy
- ☐ Moderate energy
- ☐ Low energy

Dietary Factors- please indicate if you (personally) have a history of the following (circle one)

Anemia: YES NO

Gastrointestinal Disorder: YES NO

Hypoglycemia: YES NO

Thyroid Disorder: YES NO

Pre/ Postnatal: YES NO

BrittniCastillo

Personal Trainer-Womens weightloss-Nutrition

Health history Questionnaire

Cardiovascular- Please indicate if you (personally) have a history of the following (circle one)

High blood pressure:	YES	NO
Hypertension:	YES	NO
High Cholesterol:	YES	NO
Hyperlipidemia:	YES	NO
Heart Disease:	YES	NO
Skipped Heartbeat:	YES	NO
Stroke:	YES	NO
Bypass or Cardiac Surgery:	YES	NO
Angina:	YES	NO
Gout:	YES	NO
Phlebitis or Embolism:	YES	NO
Other (please explain):	YES	NO

Please list any other diagnosed conditions and the date of diagnosis below:

_____

_____

_____

_____

_____

_____

_____

BrittniCastillo

Personal Trainer-Womens weightloss-Nutrition

Health history Questionnaire

Pain history- check if you have or had pain in the following. If yes, please describe:

- ☐ Head/ Neck: .....
- ☐ Upper Back: .....
- ☐ Shoulder/ Clavicle: .....
- ☐ Arm/ Elbow: .....
- ☐ Wrist/ Hand: .....
- ☐ Lower Back: .....
- ☐ Hip/ Pelvic: .....
- ☐ Arthritis: .....
- ☐ Hernia: .....
- ☐ Surgeries: .....
- ☐ Other: .....

Nutrition

Are you on any specific food/ diet plan? YES NO
If yes, please list and advise who prescribed it:

Do you take dietary supplements? YES NO
If yes, please list:

Do you notice your weight fluctuating? YES NO

Have you experienced a recent weight gain or loss? YES NO
If yes, explain how:

Over what amount of time?

If you consume caffeine, what types of beverages do you consume that contain caffeine?

How would you describe your current nutritional behaviors?

Other food/ nutritional issues you want to include (food allergies, mealtimes, etc.)

BrittniCastillo

Personal Trainer-Womens weightloss-Nutrition

Health history Questionnaire

Work and Environment

Please check the box that best describes your work and exercise habits:

- ☐ Intense occupational and recreational effort
- ☐ Moderate occupational and recreational effort
- ☐ Sedentary occupational and intense recreational effort
- ☐ Sedentary occupational and moderate recreational effort
- ☐ Sedentary occupational and light recreational effort
- ☐ Complete lack of activity

How stressful are your environments? (circle one)

Work: Minimal/ Moderate/ Average/ Extremely

Home: Minimal/ Moderate/ Average/ Extremely

Do you work more than 40 hours per week? YES NO

Anything else you would like your personal trainer to know?

Printed Name ……

Signature …… Date……

Signature of parent: ……
Or guardian(for participants under 18)

Witness ……