

Peak Performance Fitness. LLC

Personal Health/Medical History Questionnaire

Personal Information

Today's date: _____

Title: O DR. O Mr. O Mrs. O Ms.

Name: _____ Birth date: _____

First Name Last Name Age: _____

Address: _____ Phone: (Home) _____

City: _____ Phone: (Work) _____

Email: _____ Phone: (Cell) _____

Occupation: _____

Gender: Male _____ Female _____ Height: _____ Weight: _____

Person to contact in case of emergency: _____ Tel: _____

Physician's Name: _____ Tel: _____

Medical History

Please indicate if any of these statements apply to you by placing YES in the space provided (* past or current):

1. History of heart problem (i.e. Chest pain, heart murmur, or stroke) _____
2. Diabetes Mellitus _____
3. Asthma, breathing, or lung problems _____
4. Allergies _____
5. Cancer (other than skin) _____
6. Seizures, seizure medication, neurological problems, dizziness _____
7. High blood pressure _____
8. Back problems, joint or muscle disorder still affecting you _____
9. Recent surgery (last 12 months) _____
10. Hernia or any condition that may be aggravated by exercise _____
11. Physician's advice not to exercise _____
12. History of high cholesterol _____

- 13. Family history of coronary heart disease? _____
- 14. Do you smoke tobacco products _____
- 15. Do you consume alcohol? _____
- 16. Do you take supplements of any kind? _____
- 17. Are you on medication? _____
- 18. Do you have joint problems that might be aggravated by exercise? _____
- 19. Is stress from daily living an issue in your life? _____

Skeletal Injuries

Back _____

Neck _____

Head _____

Knee(R, L) _____

Shoulder(R, L) _____

Other injuries: _____

Surgery: _____

Please describe any special considerations or how your injury currently affects your ability to function: (i.e. Illness or Injury)

Please talk with your doctor by phone or in person before you start any new training program or have a fitness assessment. Tell your doctor about your health questionnaire and which questions you answered yes.

Goals

1. What are your concerns and goals? (example: fat loss, strength, power, muscular endurance, cardio fitness, flexibility, agility, core stability or balance)

2. Why do you want to achieve these goals? (Examples: general health, injury prevention/rehab, sport –specific training, aesthetic reasons)

3. What areas do you want to concentrate on or emphasize? (i.e. specific areas to strengthen, joint stability, cardio or core conditioning)

Fitness History

4. How long has it been since you have exercised regularly? (2 or more times/week).

5. Do you have experience with free weights or functional stability training?

6. What type of cardiovascular exercise are you familiar with?

7. If you are an experienced exerciser or athlete, what exactly is your current program? _____

8. Are there any exercises that are contraindicated or not recommended by your physician or physical therapist? _____

9. How would you describe your level of daily activities? Please check one.

Light (office work)___ Moderate(Manual labor)___ Heavy (construction)___

10. Stress (high=5, low=1) please circle one.

Physical 1 2 3 4 5 Personal/ Emotional 1 2 3 4 5 Mental/Career 1 2 3 4 5

11. Present method of handling stress:

12. Number of hours of sleep per night? _____

13. What is your available time and frequency for exercise?

What days: M T W TH F

What times: AM _____ PM _____

14. Any special considerations or requests?
