MISSION ACCOMPLISHED PERSONAL TRAINING

MEDICAL HISTORY FORM & QUESTIONNAIRE

NAME: E-MAIL ADDRESS:

MAILING ADDRESS:

HOME PHONE #: WORK PHONE #:

DATE OF BIRTH: AGE:

LEVEL OF PHYSICAL ACTIVITY: Mildly Active

Are you currently involved in a regular exercise program? Yes No

Do you practice weight training or calisthenics regularly? Yes No

If yes, how many workouts per week?

Do you perform stretching exercises on a regular basis? Yes No

If yes, how often?

NOTES ON CURRENT ACTIVITY LEVEL/TRAINING PROGRAM:

WHAT ARE YOUR TOP 3 GOALS FOR THIS FITNESS PROGRAM?

1)

2)

3)

How much time do you realistically have to commit to your fitness program per day/ per week?

What would your ideal weekly training program look like?
(*as far as time spent each day and activities you would prefer on each day*)

MON. TUES. WED. THURS. FRI. SAT. SUN.

Are there any activities that you enjoy doing or would like to try that you would like incorporated into your program?

DAILY NUTRITIONAL INTAKE:

How would you rate your nutritional habits:

On a scale of 1 to 7 rate yourself: **(1=Never/7=Always)**

1 I eat without feeling deprived
1 I eat when I am physically hungry
1 I feel in control of food instead of food controlling me
1 I stop eating when/before my stomach is physically full
1 I have ways other than eating to cope with my emotions
1 I can feel good about myself even if I eat "unhealthy"
1 I select low fat foods when eating out
1 I modify high fat recipes to make them low-fat
1 I am self-motivated to make healthy food choices
1 I eat slowly
1 I practice portion control at mealtimes and snacks
1 I eat my usual meals even if I ate too much the previous day/meal

Give an example of a normal day of eating:

Morning Mid-Day Evening Snack(s)

Have you ever been on a special diet? Yes No

If yes, what type?

How long were you on it?

What were the results?

short-term:

long-term:

Are you currently on a special diet? Yes No

If yes, what type?

How long have you been on it?

Do you or have you ever used diet shakes/pills? Yes No

If yes, what?

Do you take any vitamins/minerals or ergogenic aids? Yes No

If yes, what?

HYPERTENSION:

Have you ever been diagnosed with high blood pressure? Yes No

If yes, how long ago?

Are you on medication for it? Yes No

SMOKING:

Do you smoke? Yes No

If no, did you ever smoke? Yes No

How long ago?

If yes, how much do/did you smoke?

If you currently smoke, do you want to quit? Yes No

HEART:

Have you ever been diagnosed with heart problems? Yes No

If yes, explain:

Do you suffer chest pain? Yes No

Do you ever feel faint or have dizzy spells? Yes No

Have you ever been prescribed medication for your heart? Yes No

If yes, explain:

Is there a family history of heart disease, hypertension, stroke, diabetes, lung disease, or epilepsy?

Yes No

If yes, please provide information regarding who the relative is, the medical problem, and the age of onset or death of the individual:

MUSCULOSKELETAL:

Have you ever been diagnosed with joint or soft tissue problems? Yes No

If yes, explain:

Do you have any acute or chronic Injuries that I should be aware of? Yes No

If yes, please explain:

Do you have problems with your:

- Upper back
- Lower back
- Neck
- Shoulders
- Elbows
- Wrists
- Hips
- Knees
- Ankles
- Other:_____

If you checked any of the above, please explain:

PAST & PRESENT PERSONAL HEALTH HISTORY

(Please check if you have or have had any of the following)

- Disease of the arteries or heart
- Diabetes or abnormal blood sugar
- High blood pressure
- Angina (Chest Pain)
- Epilepsy
- Stroke
- Anemia (Type? If known:)
- Abnormal chest X-ray
- Cancer
- Asthma (If yes, do you carry an inhaler?)
- Other lung/pulmonary disease?
- Orthopedic problems

If you checked any of the above, please explain further and indicate any recommendations or limitations prescribed by a doctor:

Please list any medications or supplements you are currently using:

Are you pregnant? Yes No

If yes, has your doctor approved that you begin/continue an exercise program? Yes No

Are you over 65 years and unaccustomed to vigorous exercise? Yes No

If yes, has you doctor approved that you begin an exercise program?

Is there any other physical reason, not already mentioned here, why you should not follow a fitness program? Yes No

If yes, what?

IN CASE OF AN EMERGENCY CONTACT:

NAME:

PHONE #:

PHYSICIAN'S NAME:

PHONE #:

I have answered all questions on his Medical
(Print Name)

History Form & Questionnaire completely and honestly to the best of my knowledge.

(Signature) (Date)