Health History Questionnaire

QUESTIONS ARE CONFIDENTIAL				
Name:	Date of Birth:	Age:		
Address:	Email:			
City, State, Zip:				
Employer:	Occupation:			
Does your occupation require extended periods of sitting?		□ Yes	□ No	
Does your occupation require extended periods of		□ Yes	□ No	
repetitive movements?				
If yes, please explain:				
Does your occupation require you to wear shoes with a heel		□ Yes	□ No	
(dress shoes)?				
Does your occupation cause you anxiety (mental stress)?		□ Yes	□ No	
In case of emergency, please notify:				
Name:	Relationship:			
Address:				
City, State, Zip:				
Home Phone:	Work Phone:			
MEDICAL INFORMATION:				
Physician:	Phone:			
Are you under the care of a physician, chiropractor, or other health care professional for				
any reason?		□ Yes	□ No	
Are you taking any medication?		□ Yes	□ No	
(If yes, complete the following)				
Type:	Dosage:Frequency:	Reason for Taking:		

Health History Questionnaire

MEDICAL INFORMATION, *CONTINUED*

Please list any allergies:

Has your doctor ever said your blood pressure was too high?	□ Yes	□ No	
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	□ Yes	□ No	
Are you over the age of 65?	□ Yes	□ No	
Are you unaccustomed to vigorous exercise?	□ Yes	□ No	
Is there any reason not mentioned why you should not follow a regulare exercise program?	□ Yes	□ No	
If yes, please explain:			

SMOKING

Please check the box that describes your current habit:

	□ Non-user or former user; Date quit:_____
	□ Cigar and/or pipe
	□ 15 or less cigarettes/day
	□ 16-35 cigarettes/day
	□ More than 35 cigarettes/day

FAMILY AND PERSONAL MEDICAL HISTORY

If there is a family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

	□ Asthma:_____
	□ Respiratory/Pulmonary Condition:_____
	□ Diabetes: Type I:_____ Type II:_____ How long?_____
	□ Epilepsy: Petite Mal:_____ Grand Mal:_____ Other:_____
	□ Osteorporosis:_____

LIFESTYLE AND DIETARY FACTORS

Please fill in the information below:

	□ Occupational Stress Level: □ Low / □ Medium / □ High
	□ Energy Level: □ Low / □ Medium / □ High
	□ Caffeine Intake/Daily:_____ □ Alcohol Intake/Weekly:_____
	□ Colds Per Year:_____ □ Anemia:_____
	□ Gastrointestinal Disorder:_____
	□ Hypoglycemia:_____
	□ Thyroid Disorder:_____
	□ Pre/Postnatal:_____

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FAMILY AND PERSONAL MEDICAL, *CONTINUED*				
CARDIOVASCULAR				
Please fill in the information below:				
	□ High Blood Pressure:_____ □ Hypertension:_____			
	□ High Cholesterol:_____			
	□ Hyperlipidemia:_____			
	□ Heart Disease:_____			
	□ Heart Attack:_____ □ Stroke:_____			
	□ Angina:_____ □ Gout:_____			
MUSCULOSKELETAL INFORMATION				
Please describe any past or current musculoskeletal conditions you have incurred				
(Pulls, sprains, fractures, breaks, surgery, back pain, or general discomfort):				
	□ Head/Neck:_____			
	□ Upper Back:_____			
	□ Shoulder/Clavicle:_____			
	□ Arm/Elbow:_____			
	□ Wrist/Hand:_____			
	□ Lower Back:_____			
	□ Hip/Pelvis:_____			
	□ Thigh/Knee:_____			
	□ Arthritis:_____			
	□ Hernia:_____			
	□ Surgeries:_____			
	□ Other:_____			
NUTRITIONAL INFORMATION:				
Are you on any specific food/diet plan at this time?		□ Yes	□ No	
If yes, please describe:				
Do you experience any frequent weight fluctuations?		□ Yes	□ No	
Have you experienced a recent weight gain or loss?		□ Yes	□ No	
If yes, please describe:				
Do you take dietary supplements?		□ Yes	□ No	
If yes, please list:				

Health History Questionnaire

FAMILY AND PERSONAL MEDICAL, *CONTINUED*

How would you describe your current nutritional habits?

Other food/nutritional issues you would like to include? (*food allergies, mealtimes, etc.*)

How would you describe your current exercise habits?

What are you overall health goals?

LEGAL

I will commit myself wholeheartedly to my goals and I will share my goals with _____

and ask him/her to hold me accountable.

Signature:_____

Date:_____

I understand that Joy is not a licensed dietician. As a National Academy of Sports Medicine Certified Fitness Nutrition Specialist, she can only provide an example of healthy meal options. If I schedule a nutrition consultation with her, I will consult with my physician before beginning any new exercise or nutrition program.

I, _____, certify and acknowledge:

That Joy Kushner, an independent personal trainer, has advised me prior to my commencement of participation in cardiovascular and resistance training programs that such participation could result in physical injury.

That I, _____, freely and knowingly assume the risk in such programs, and I hereby waive any right, claim, or cause of action against Joy Kushner, Company name Joy Personal Training, and release her and/or her company from any liability for any injury, cost, damage expense or claim, which I or anyone on my behalf might incur as a direct result of my participation in this cardiovascular and resistance-training program.

That I,_____have read this Liability Waiver form, understand and agree with each of the foregoing points, and have receied a copy of this release form on this date.

Print Name:_____

Signature:_____

Date:_____