



## HEALTH HISTORY QUESTIONNAIRE

Today's Date: \_\_\_\_\_

Name: _____	Date of Birth	____/____/____	Age: _____	
		M	D	Y
Address: _____	Street	City	Province	Postal Code
Phone: _____	(h)	(o)	(cell)	
Email address: _____				
Occupation: _____				
Emergency Contact: _____	Phone: _____			
Physician's Name: _____	Phone: _____			

**Kindly provide a 24 hour notice if you need to cancel or reschedule your appointment.**

### DO YOU HAVE, OR HAVE YOU HAD, IN THE PAST (Par-Q):

- |  |            |           |
|--|------------|-----------|
| 1. History of heart problems, chest pain or stroke?                      | <b>YES</b> | <b>NO</b> |
| 2. Increase or decreased blood pressure?                                 | <b>YES</b> | <b>NO</b> |
| 3. Any chronic condition or illness?                                     | <b>YES</b> | <b>NO</b> |
| 4. Encouraged by a doctor to begin an exercise program.                  | <b>YES</b> | <b>NO</b> |
| 5. Recent surgery (last 12-months).                                      | <b>YES</b> | <b>NO</b> |
| 6. Pregnancy (now or within the last 3-months)                           | <b>YES</b> | <b>NO</b> |
| 7. History of breathing problems.  | <b>YES</b> | <b>NO</b> |
| 8. Muscle, joint, back disorder or any other injury still affecting you. | <b>YES</b> | <b>NO</b> |
| 9. Diabetes or thyroid condition.  | <b>YES</b> | <b>NO</b> |
| 10. Cigarette smoking habit.   | <b>YES</b> | <b>NO</b> |
| 11. Increased blood cholesterol.   | <b>YES</b> | <b>NO</b> |
| 12. History of heart problems in immediate family.                       | <b>YES</b> | <b>NO</b> |

13. Hernia or any other condition that may be aggravated by lifting weights. **YES** **NO**

14. Are you taking any prescription medications? **YES** **NO**

Please list medications and dosage:

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Please explain **in detail** any **YES** answers to the previous & this page's questions:

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What are you currently doing for exercise (please be as specific as you can)?

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What type of exercise interests you?

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Have you worked with a trainer before? \_\_\_\_\_

What sort of activities does your job involve – computer, driving, desk job, lifting, walking, on the phone a lot. Other: \_\_\_\_\_

Is your job – active                      sedentary                      stressful

What are your top three exercise goals for the **next 6 months**?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Are there any other reasons that could prevent or limit you from exercising?

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Where do you plan to perform your workouts when NOT with me & how times per week can you realistically commit?

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How did you hear about me? \_\_\_\_\_

If you were referred to me, who told you about my services? \_\_\_\_\_

What would cause you to discontinue training with me? \_\_\_\_\_

Do you have anything else that you would like to add that aid me in designing your workout program?

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**Trainer's Notes:**