IVERSON FITNESS & WELLNESS CONSULTING, LLC

HEALTH AND MEDICAL QUESTIONNAIRE

Name: _____ Date of birth: _____

Address:_____
Street City State Zip

Phone (Cell): _____ (Home/Work): _____

Email address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (Cell):_____ (Home):_____

Personal Physician

Name: _____ Phone: _____

Address: _____Fax: _____

Present/Past History

Have you had or do you presently have any of the following? (Check if yes.)

_____ Rheumatic fever

_____ Recent operation

_____ Edema (swelling of ankles)

_____ High blood pressure

_____Low blood pressure

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www.ExerciseisMedicine.org

_____ Injury to back or knees

_____ Seizures

_____ Lung disease

_____ Heart attack or known heart disease

_____ Fainting or dizziness

_____ Diabetes

_____ High Cholesterol

_____ Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) or nocturnal dyspnea (shortness of breath at night)

_____ Shortness of breath at rest or with mild exertion

_____ Chest pains

_____ Palpitations or tachycardia (unusually strong or rapid beat)

_____ Intermittent claudication (calf cramping)

_____ Pain, discomfort in the chest, neck, jaw, arms, or other areas

_____ Known heart murmur

_____ Unusual fatigue or shortness of breath with usual activities

_____ Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body

_____ Cancer

_____ Other (please describe): _____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

_____ Heart attack

_____ Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)

_____ Congenital heart disease

_____ High blood pressure

_____ High cholesterol

_____ Diabetes

_____ Other major illness: _____

Please explain any checked items:

_____
_____
_____
_____

Physical Activity History

1. How were you referred to this program? (Please be specific.)
   _____
2. Why are you enrolling in this program? (Please be specific.)
   _____
3. Have you ever worked with a wellness coach or personal trainer before?

   Yes _____ No _____
4. Date of your last physical examination performed by a physician:
   _____
5. Do you participate in a regular exercise program at this time?
   Yes _____ No _____

If yes, briefly describe:

_____

5. Can you currently walk 4 or more miles briskly without fatigue?

   Yes _____ No _____

6. Have you ever performed resistance training in the past?

   Yes _____ No _____

7. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes _____No _____ If yes, briefly describe:
   _____

8. Do you smoke? Yes _____ No _____ If yes, how much per day and what was your age when you started? Amount per day _____ Age _____

9. What is your body weight now? _____What was it one year ago? _____

10. What is your "ideal" body weight? _____

11. How tall are you? _____

12. Do you follow or have you recently followed any specific dietary intake plan and, in general, how do you feel about your nutritional habits?
    _____
    _____

13. List the medications you are presently taking.
    _____
    _____

14. List in order your personal health and fitness objectives.
    a. _____
    b. _____
    c. _____
    d. _____

As you Personal Health Fitness Specialist, it is my responsibility to implement a safe & effective training program based on your current health history and personal training goals. Please let me know if there are any concerns, limitations or issues that you would like me to be aware of.

Signarure:_____Date:_____