

THE BODY SHOP HEALTH & WELLNESS CENTER, LLC

HEALTH & MEDICAL QUESTIONNAIRE

Name: _____ Date of birth: _____

Date: _____

Address: _____

Street City State Zip

Phone (Cell): _____ (Work): _____

Email address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Phone (Cell): _____ (Home): _____

Personal physician

Name: _____ Phone: _____

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
- _____ 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: _____

Explain checked items :

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 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 miles briskly without fatigue? Yes _____ No _____
6. Have you ever performed resistance training exercises 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? _____
At age 21? _____
10. How tall are you?
11. Do you follow or have you recently followed any specific dietary intake plan and, in general, how do you feel about your nutritional habits?

12. List the medications you are presently taking.

13. List in order your personal health and fitness objectives.

- a. _____
- b. _____
- c. _____
- d. _____