Beverly Hills Los Angeles Hollywood

L.A. Star Fitness

Your Personal Training Group

www.LAStarFitness.com

HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your answers will be kept confidential.

Name: _____ Date of Birth: _____/_____/ _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Physician: _____ Phone: _____

Address: _____

City, State, Zip: _____

In case of emergency, please notify:

Name: _____ Relationship: _____

Address: _____

City, State, Zip: _____

Phone: _____

1. Are you under the care of a physician, chiropractor, or another health care professional for any reason?
   □ Yes □ No

   If Yes, list reason: _____

   _____

   _____

2. Are you taking any medications? □ Yes (if Yes, complete the following) □ No

Type	Dosage/Frequency	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	

3. Please list any allergies: _____

_____

_____

4. I am not aware of any disease or disorder that would complicate my participation in a testing or exercise program, other than the medical conditions I have checked below:

   Age _____ Gender: (circle) Male Female

Note: In order to assist you in the development of a rewarding physical fitness program, we need to have your honest and accurate responses.

4-1. Has your doctor ever said your blood pressure was too high? □ Yes □ No

4-2. 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

4-3. Are you over age 65? □ Yes □ No

4-4. Are you unaccustomed to vigorous exercise? □ Yes □ No

4-5. Is there any reason not mentioned here why you should not follow a regular exercise program? □ Yes □ No

If so, please explain: _____

_____

_____

4-6. Have you recently experienced any chest pain associated with either exercise or stress? □ Yes □ No

If so, please explain: _____

_____

_____

4-7. Do you have a family history of any of the following conditions? (check all that apply)

- □ Heart Disease
- □ Heart Attack
- □ Hypertension
- □ High Cholesterol
- □ Gout
- □ Angina
- □ Abnormal EKG
- □ Diabetes
- □ Asthma
- □ Other heart condition

SMOKING

Please check the box that best describes your current habits:

- □ Non-user or former user. (Date quit: _____)
- □ Cigar and/or pipe
- □ 15 or less cigarettes per day
- □ 16 to 25 cigarettes per day
- □ 26 or 35 cigarettes per day
- □ More than 35 or less cigarettes per day

FAMILY HISTORY OF CARDIOVASCULAR DISEASE (CV)

Please check the boxes that best describe your personal family history (blood relatives only):

- □ No known history of heart disease in family
- □ One relative over age 60 with CV Disease
- □ Two relatives over age 60 with CV Disease
- □ One relative under age 60 with CV Disease
- □ Two relatives under age 60 with CV Disease
- □ Three relatives under age 60 with CV Disease

MUSCLOSKELETAL

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

head / neck _____
upper back _____
shoulder / clavicle _____
arm / elbow _____
wrist / hand _____
lower back _____
hip / pelvis _____
thigh / knee _____
lower leg / ankle / foot _____

NUTRITIONAL

Are you on any specific food / nutritional plan at this time? □ Yes □ No

If yes, please list: _____

Do you take dietary supplements? □ Yes □ No

If yes, please list: _____

Do you experience any frequent weight fluctuations? □ Yes □ No

Have you experienced a recent weight gain or loss? □ Yes □ No

If Yes, list change: _____ Over how long? _____

How many beverages do you consume per day that contain caffeine? _____

EXERCISE

Please check the box that best describes your work and exercise habits:

- □ Intense occupational and recreational exertion
- □ Moderate occupational and recreational exertion
- □ Sedentary work and intense recreational exertion
- □ Sedentary work and moderate recreational exertion
- □ Sedentary work and light recreational exertion
- □ Complete lack of all exertion

To what degree do you perceive our environment as stressful?

- □ Minimal □ Moderate
- □ Average □ Extremely

Please make any other comments you feel are pertinent to your exercise program.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of CLIENT DATE

_____ _____

Signature of WITNESS DATE