HealthFIT
Health Assessment and Exercise Questionnaire

All information in the following questionnaire is kept strictly confidential, and is solely for the use of Maren Sederquist or other HealthFIT employees or independent contractors, to ensure that the safest and most effective exercise program is prescribed for you. Communications will only be made with any of your physicians or other health care workers upon receiving your permission first.

Date _____

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Referred By _____

Age _____ Date of Birth _____ Gender: F ☐ M ☐

Height _____ Weight _____

Occupation _____ Time spent at work each day _____

How would you describe your overall physical health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

When did you have your last medical exam? _____

Physicians and phone numbers:

_____

_____

_____

Please list the name and dosage of any prescriptions you are currently taking:

_____

_____

_____

Please list any vitamin or herbal supplements you are currently taking.

_____

_____

_____

How many caffeinated beverages do you drink daily? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ ☐

Do you smoke? Never ☒ If quit, how long ago? _____ If current, how many/day? _____

How much alcohol do you drink? None ☐ 1-3 drinks/wk ☐ 4-7/wk ☐ 8-14/wk ☐ 15+/wk ☐

Please list any allergies you have to any medications, foods, or environmental stimuli:

_____

_____

_____

Do you have high blood pressure? Yes ☐ No ☐

What was your last blood pressure reading, and when was it? _____

Do you have high blood cholesterol levels? Yes ☐ No ☐

What was your last cholesterol reading (LDL, HDL, total) and when was it? _____

Do you have high a triglyceride level? Yes ☐ No ☐

What was your last triglyceride reading and when was it? _____

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Have you ever been told by your doctor that you should only do physical activity recommended by them or under their supervision? Yes ☐ No ☐

Have you ever had a physician's advice to not exercise for any reason at all? Yes ☐ No ☐

Do you have a history of heart problems? Yes ☐ No ☐
Do you have a history of chest pain? Yes ☐ No ☐
Do you have a history of stroke? Yes ☐ No ☐

Do you have a family history of heart disease before 55? Yes ☐ No ☐
Do you have a family history of obesity? Yes ☐ No ☐
Do you have a family history of diabetes? Yes ☐ No ☐

Have you ever experienced pain or discomfort in the neck, left shoulder or arm, or mid-chest in response to exertion? Yes ☐ No ☐

Have you ever had chest pain when you were not doing physical activity? Yes ☐ No ☐

Do you have diabetes? Yes ☐ No ☐

Do you have a history of breathing or lung problems? Yes ☐ No ☐

Do you experience breathlessness after mild energy exertion? Yes ☐ No ☐

Do you ever have dizzy spells, feel faint, lose your balance, or lose consciousness? Yes ☐ No ☐

Do you have a thyroid condition? Yes ☐ No ☐

Do you have ulcers or any other digestive disorders? Yes ☐ No ☐
If yes, please elaborate: _____

Have you ever had a hernia, or other condition that may be aggravated by weightlifting? Yes ☐ No ☐

Do you have any other chronic illnesses or conditions? Yes ☐ No ☐
If so, please explain: _____

Have you had any surgeries within the last 12 months? Yes ☐ No ☐
If yes, please list surgery & date: _____

Are you pregnant now, or have been in the last 3 months? Yes ☐ No ☐

How well and much do you sleep? _____

How many times do you eat per day? _____

Do you have cravings for any particular foods? Yes ☐ No ☐
If yes, please list: _____

Have you ever suffered from any eating disorders? _____

Do you have any difficulty exercising? _____

Do you have any deficits in function? (Is there anything you'd like to be able to do that you feel you can't, due to physical limitations?)

_____

_____

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Do you have any muscle, joint, or back problems? Yes ☐ No ☐
(Please specify if any.)

Do you have any previous injuries that may reoccur once you start exercising? Yes ☐ No ☐
(Please specify if any.)

Do you have any current pains or problem areas? Yes ☐ No ☐
(Please specify if any.)

Do you have any arthritic conditions? Yes ☐ No ☐
(Please specify if any.)

Please list any other medical history that may be relevant to starting an exercise program:

What are your reasons for wanting to start an exercise program?

What are your goals, and in what time-line? (Please be as specific as possible.)

What is your current activity level? (Please include frequency, duration, and intensity.)

What is your exercise history? (Have you always been active or sedentary?)

What activities have you done, and how often?

What types of activities/sports/exercise do you enjoy?

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Are there any new types of activities/sports/exercise that you are interested in trying?

Do you have a time of day you prefer to exercise?

Does your occupation require much activity? _____
If so, what type? (walking, getting up and down, carrying things, lifting, etc.)

What are your usual leisure activities? _____
Do you feel you are under stress? Yes ☐ No ☐
What types of things normally make you feel stressed?

How do you normally deal with stress? _____

Do you have a significant other or friends who are involved in regular exercise? Yes ☐ No ☐
If yes, please list who. _____

Do you feel your family, friends and coworkers will be supportive of your efforts, or might they feel disapproval or resentment toward your efforts at physical activity?

What is your attitude toward exercise? (Are you competitive or easy going? Do you love or hate exercise? Do you need goals and structure, or are you better being flexible and paying attention to how you feel?)

How much of a commitment are you willing to make toward your goals? (Time per day, days per week, effort, limitations?)

Why did you quit any exercise program in the past? _____

What exercise equipment do you have available to use? _____

Is there any other information you would like me to have, that you think will help me help you get to your goals?