

Medical History / Lifestyle Questionnaire

In order to design a safe and effective program it is important that you complete the following form. All information is strictly confidential.

Name: _____ age: _____ Date of birth: _____

Address/City/State/Zip: _____

Home phone: _____ work/cell: _____ e-mail: _____

Current weight: _____ Height: _____ Most you have weighed: _____ Comfortable weight: _____

Who is your physician: _____

When was your last physical examination? _____

*Do you have any chronic illnesses (if so please list)?

Have you ever been hospitalized? Y N

Type of operation(s):

Month and year hospitalized _____

Is there a history of heart disease in your family? Y N Who? _____

Is there a history of cancer in your family? Y N Who and what type? _____

*Are you pregnant or have you been pregnant recently? Y N

*During the past 12 months....

Has a physician prescribed and form of medication for you? Y N (if yes circle)

Blood thinner Diabetic pill Digitalis Diuretic Heart-rhythm medication insulin

High-blood-pressure medication cholesterol medication Epilepsy medication
other? _____

Has your weight fluctuated more than just a few pounds? Y N

If yes, did you attempt to bring about this weight change by diet and/or exercise? Y N

Please comment: _____

*Have you experienced unusual heartbeats such as skipped beats palpitations? Y N

*Have you experienced periods in which your heart felt as though it were racing? Y N

*Have you experienced any faintness, light-headedness, or blackouts? Y N

At present....

*Do you experience shortness of breath while walking with others your own age? Y N

*Do you experience sudden tingling, numbness, or loss of feeling? Y N

*Do you experience swelling of your feet and ankles while walking or at rest? Y N

*Do you get pains or cramps in your legs? Y N

*Do you experience any pain or discomfort in your chest? Y N

*Have you ever been told that your blood pressure was abnormal? Y N

What is your blood pressure?____/____

*Have you ever been told that your cholesterol was high? Y N

Cholesterol_____ Triglyceride level_____ (if known)

*Do you have diabetes? Y N

If so, how is it controlled?_____

How often would you characterize your stress level as being high?

Very often Fairly often Sometimes Infrequently Practically never

*Have you ever had an orthopedic injury? Y N

Lower back Upper back Hips Knees Shoulders Wrists Other_____

Explain_____

*Have you ever been diagnosed with tendonitis, arthritis, or bursitis? Other_____

*** IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, IT IS STRONGLY RECOMMENDED THAT YOU OBTAIN PHYSICIANS CONSENT.**

Do you exercise on a regular basis? Y N



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If you walk and/or run, what is the number of miles you cover each workout? ___miles ___min

How many moderate to strenuous workouts per week do you participate in on average?
___workouts

What are some of your favorite activities? _____

Is your occupation...

- ___Inactive (e.g. desk job)
- ___Light work (e.g. housework, light carpentry)
- ___Heavy work (e.g. heavy carpentry, lifting)

Have you ever had your body fat % calculated? Y N ___BF% month/ year___

Would you be interested in having your body fat calculated? Y N

Have you ever smoked cigarettes, cigars, or pipes? Y N

Do you smoke presently? Y N How many per day?___ When did you start?___

If you have quit, when?_____

On average, how many glasses of beer___, wine___, or highballs___do you consume a week?

How would you rate your diet? Excellent Very good Good Not the best Poor

How many meals a day do you consume on average?_____

Do you tend to snack throughout the day? Y N On what?_____

How many times a week do you eat the following....

- ___cookies,cakes,pie ___Candy ___Diet soda ___Soft drinks ___Doughnuts ___Fruit ___milk or milk beverage ___Ice cream ___Chips ___Nuts ___Cheeses & crackers

How often do you eat dessert___a day ___a week? Favorite_____

How often do you eat fried foods?_____

Would you consider yourself to be knowledgeable in health and nutrition? Y N

What would you like to gain more knowledge on?_____



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Would you read handouts and would they be helpful to you ? Y N

List some of the goals you hope to get out of a fitness program. _____

Goals by Importance

Please number by order of importance, #1 being most important

- _____ Muscular Endurance
- _____ Reduce Weight & Tone
- _____ Increase Flexibility
- _____ Increase Energy
- _____ Increase Cardiovascular Fitness
- _____ Muscular Strength
- _____ Relieve Stress
- _____ Improve Overall Well Being
- _____ Other

Have you ever participated in a weight training program? Y N

If yes, what were some of the things you likes and disliked? _____

What are some of the fears and/or anxieties you may have about starting an exercise/weight training program? _____

Would you follow extra written programs to be done at home? Y N

Would this be helpful? Y N

Would you like to be on my e-mail list and receive health articles periodically? Y N

Would you enjoy going outside for a change of pace? Y N

Would you be opposed to working out with a partner? Y N

What is the most convenient day and time for you? _____

How flexible are you with your schedule? _____

**EXERCISE PARTICIPATION INFORMED CONSENT AND
WAIVER FORM**

I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, is a potentially HAZARDOUS ACTIVITY. I also understand that fitness activities involve RISK OF INJURY and even DEATH and that I am voluntarily participating in these activities and do expressly assume any and all risks of injury or death.

I do hereby further declare myself to be PHYSICALLY SOUND and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any activities and programs or use of equipment and machinery. I do hereby acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity and exercise, so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician.

I do hereby ASSUME ALL RESPONSIBILITY for my participation in an exercise program.

Signature

Date

Name (please print)

RATES and POLICIES

My goal is to challenge you to your full potential while making exercise fun and enjoyable for you. I feel that education is a very important component and I will provide you with up to date research summaries of the latest health and fitness news. I am always open to suggestions and appreciate your input.

My policies:

I am flexible with my schedule and I am more than happy to accommodate your needs. However, please allow some notice so that I may make other arrangements if you are not able to show up for your appointment. If possible please provide 24 hour notice for cancellations or changes. There will be a session charge missing an appointment without notice.

Rates per session for 2012 55 minute session

\$40 for individual
\$30 per person for 2 people
\$25 per person for 3 people
\$20 per person for 4 people