



Health/Medical History Questionnaire

This information is solely for the use of PRIDE Conditioning and Douglas Seamans. Your information is strictly confidential and will never be released to anyone without your knowledge and consent.

Name _____ Date _____ Birth Date _____

Address _____
Street City State Zip

Phone _____ Email _____

Personal Physician

Name _____ Phone _____

Personal Training PAR-Q (Physical Activity Readiness Questionnaire)

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever been diagnosed with a heart condition that requires your physician's consent to begin an exercise program? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel pain in your chest when you do physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you had chest pain when you were not doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose your balance because of dizziness or do you ever lose consciousness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a bone or joint injury (for example, back, knee or hip) that could be made worse by a change in your physical activity level? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? |

If you checked "YES" for any of the preceding questions, the "National Strength and Conditioning Association" states that you must receive clearance from your primary care physician to participate in a progressive resistance exercise program.

By signing below, you hereby agree that you have read this document and have answered all of the questions honestly and to the best of your knowledge

Last Name, First Name (please print)

Signature

Date

Medical History

Present and Past History

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

- Rheumatic fever
 - Recent operation
 - Edema
 - High blood pressure
 - Injury to back
 - Injury to knees
 - Low blood pressure
 - Seizures
 - Lung disease
 - Heart attack
 - 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 heart 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 ones side, arm or leg
 - Other (please explain) _____
-

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 ___
- ___ Congenital heart disease ___
- ___ High blood pressure ___
- ___ High cholesterol ___
- ___ Diabetes ___
- ___ Other major illness _____

Explanation of any checked items: _____

Activity History

1. How were you referred to this program?

2. What is your goal for participating in this program?

3. Are you presently employed? Yes ___ No ___
4. What is your present occupational position?

5. Name of company?

6. Have you ever worked with a Personal Trainer or fitness professional before? Yes ___ No ___
7. If so, where and how long ago?

8. Date of your last physical examination performed by a physician?

9. Do you participate in regular physical activity? Yes___ No___

Activity

Frequency

Time

10. Can you currently walk 3-4 miles briskly without fatigue? Yes___ No___

11. Have you performed resistance training exercise in the past? Yes___ No___

12. Do you have bone or muscle injuries or disabilities that may interfere with exercising?

Yes___ No___

If yes, please explain: _____

13. Do you smoke? Yes___ No___

If yes, how much per day do you smoke and at what age did you start?

Amount per day: _____ Age: _____

14. What is your current body weight? _____ What was it one year ago? _____ At age 21? _____

15. Do you consider yourself:

- a. At my goal weight/body composition
- b. At a weight/body composition lower than optimal for health and fitness
- c. At a weight/body composition higher than optimal for health and fitness

16. Do you follow or have you recently followed any specific dietary plan? Yes___ No___

If yes, please explain: _____

17. In general, how do you feel about your current diet? _____

18. List an medications, nutritional supplements or herbs that you are presently taking

Medication/supplement/herb

Dosage

Frequency

19. Please list restaurants where you frequently eat at: _____

20. How many times a week do you usually eat out at a restaurant, including lunches or breaks at your job (circle one):

0-4

5-9

10 or more

21. Who usually prepares food in your household? _____

22. Where do you typically shop for your groceries? _____

23. How many times in one month do you go grocery shopping? _____

24. How much is your typical grocery bill? _____

25. List, in order of importance, your health and fitness goals:

a. _____

b. _____

c. _____

d. _____

**To be filled out together with your fitness professional:*

Goal:

Date:

Date Achieved:

Thank you for taking the time to fill out this form truthfully and completely! We look forward to working together to achieve your health and fitness goals and building your body and mind to build your pride!