



Health & Medical History Questionnaire

Participants Name: _____

Personal Training PAR-Q (Physical Activity Readiness Questionnaire)

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes__ No__
2. Do you feel pain in your chest when you do physical activity? Yes__ No__
3. In the past month, have you had chest pain when you were not doing physical activity? Yes__ No__
4. Do you lose your balance because of dizziness or do you ever lose consciousness? Yes__ No__
5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by change in your physical activity? Yes__ No__
6. Is your doctor currently prescribing drugs for your blood pressure or heart condition? Yes__ No__

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

- Rheumatic fever Recent operation Edema (swelling or ankles) High blood pressure
 Injury to back or 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) 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 heartbeat) 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

Other 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 illnesses _____

Explain checked items: _____

If you checked “yes” for any question #1-#6, you must receive clearance from your physician prior to participating in a progressive resistance exercise program.



Health & Medical History Questionnaire

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__

ACTIVITY / FREQUENCY / TIME: _____

6. Can you currently walk 4 miles briskly without fatigue? Yes__ No__

7. Have you ever performed resistance training exercises in the past? Yes__ No__

8. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes__ No__

If yes, briefly describe: _____

9. Do you smoke? Yes__ No__ If yes, how much per day and what was your age when you started?

Amount per day_____ Age_____

10. How high is the level of stress in your life? HIGH MODERATE LOW

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

12. Do you consider yourself:

_____ At my goal weight/body composition for maintenance

_____ At a weight lower than optimal for health and fitness

_____ At a weight higher than optimal for health and fitness

13. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits? _____

14. List the medications, nutritional supplements(s)/herbs, etc. you are presently taking.

Medication / supplement or herb / Dosage / Frequency

15. List in order of importance your personal health and fitness objectives.

a. _____

b. _____

c. _____

I have read this entire document and have answered all of the questions to the best of my knowledge.

Name (please print): _____

Signature: _____

Date: _____