TRAIN SMART WITH STEPH
ISSA Certified Personal Trainer

In-home personal training focused on improving strength, fitness, and confidence in women.

TRAIN SMART WITH STEPH
814-574-0479

Health History Questionnaire

Answer each question by printing the necessary information. Your answers are confidential.

Name:____ Date of Birth:_________________________ Age:__________

Address:____

City:____ State:_________________ Zip:_______________________

Home Phone:____ Cell Phone:_______________________________________

Employer:____ Occupation: _____________________________________

Emergency Contact

Name:____ Relationship:_____________________________________

Home Phone:____ Cell Phone:_______________________________________

Medical Information

Physician Name:____ Phone:_____________________________________

Are you under the care of a physician, chiropractor, or other healthcare professional for any reason?

Yes_______ No_______

If yes, please explain:____

____

Are you taking any medications? Yes_________ No___________ (If yes, complete the following)

List Type of Medication Dosage/Frequency Reason for Taking

____

____

____

____

Please list any allergies:____

____

Has your doctor ever said that your blood pressure was too high? Yes__________ No__________

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__________

Are you over the age of 65? Yes__________ No__________

Are you unaccustomed to vigorous exercise? Yes__________ No__________

Is there any reason that you should not follow a regular exercise program? Yes__________ No__________

if yes, please explain____

Have you recently experienced any chest pain associated with exercise or stress? Yes__________ No__________

Smoking

Please check the space that describes your current habits:

______Non-smoker (never smoked)

______Non-smoker (former smoker)

Date quit________________

______Cigar or pipe

______Smoke less than 15 cigarettes a day

______Smoke more than 15 cigarettes a day

Family and Personal Medical History

For each condition, please check the most appropriate space(s). If you have the condition yourself, please explain.

Asthma Self_____ Family_______ Describe ____

Respiratory/Pulmonary Condition Self_______ Family_______ Describe____________________________________

Diabetes Self_____ Family_______ Describe____

Epilepsy Self_____ Family_______ Describe____

Osteoporosis Self_____ Family_______ Describe____

Musculoskeletal Information

Please describe any past or current musculoskeletal conditions that 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____

_____Arthritis____

_____Hernia____

_____Surgeries____

Other Comments:____

Cardiovascular Information

If you have been diagnosed with any of the following conditions?

-High blood pressure -Hypertension -High Cholesterol -Hyperlipidemia

-Heart Disease -Heart Attack -Stroke -Angina -Gout

Lifestyle and Dietary Factors

Please fill in the information below.

Occupational Stress Level _____minimal _____moderate _____average _____extremely
Stress Level Outside of Work _____minimal _____moderate _____average _____extremely
Energy Level Low______ Medium_______ High_______
Caffeine Intake Daily______________________ Alcohol Intake Weekly_____________________
Number of colds per year _________ Gastrointestinal disorder____
Hypoglycemia________ Thyroid Disorder________ Prenatal_________ Postnatal_________

What do you find are the biggest obstacle in your life for leading a healthy lifestyle (select all that apply)?
_____Finding enough time in your day to fit in exercise
_____Finding enough time to prepare healthy meals or snacks
_____Do not get enough sleep so I have no energy for exercise
_____I eat meals on the go and find myself snacking too much on unhealthy snacks
_____I drink too many sugar sweetened beverages
_____I have no willpower and we always have unhealthy foods around the house
_____I eat when I am not hungry
_____I miss meals often and then overeat when I finally sit down for a meal
_____I eat out too often
_____I consume too many alcoholic beverages
_____Other, please explain____
____

Nutritional Information

Are you on any specific food/diet plan at this time? Yes______ No______
If yes, please explain____
Do you take dietary supplements? Yes______ No______
If yes, please explain____
Do you experience any frequent weight fluctuations? Yes______ No______
Have you experience a recent weight gain or loss? Yes______ No______
If yes, please explain____
How would you describe your current nutritional habits?____
____
Other food/nutritional issues that you want to include (food allergies/mealtimes/etc.).________________________
____

Work and Exercise Habits

Please check the space that best describes your work and exercise habits.

_____Intense occupational and recreational exertion

_____Moderate occupational and recreational exertion

_____Sedentary occupational and intense recreational exertion

_____Sedentary occupational and moderate recreational exertion

_____Sedentary occupational and light recreational exertion

_____No occupational or recreational exertion

How many hours do you work per week on average?

_____I do not work

_____Less than 20 hours

_____Between 20-40 hours

_____Over 40 hours

Personal Health and Wellness Goals

Please check all that apply to your personal health and wellness goals.

Lose weight _____ Rehabilitate an injury_____ Improve motivation______ Improve strength_____

Learn more about fitness______ Improve self-confidence______ Gain muscle______

Reduce Stress_____ Improve sport performance_____ Improve cardiovascular health_____

How many days do you feel you could dedicate to improving physical activity per week? ________

Do you feel like you need assistance with nutrition or lifestyle decisions related to your health? ________

Please use this space to make any other comments that you feel are important to your exercise program.

____

Name (please print):____

Signature:____ **Date:**__________________________