HEALTH HISTORY

Name_____ Date

Address _____City

Province _____ Postal Code _____Home Telephone

Business Telephone _____Emergency Contact Telephone

Name _____ Relationship _____Doctor's Name

Telephone _____Date of Birth _____ Male

Female Weight_____ Height

Referred By _____

E-mail _____

In order to design a safe and effective fitness program it is important that you complete the following Health History. It is crucial that you answer ALL the questions honestly and to the best of your ability. Please be advised that all information is kept strictly confidential.

Does your physician know that you are participating in an exercise program? ☐ yes ☐ no

Have you filled out the Physical Activity Readiness Questionnaire - Par Q? ☐ yes ☐ no

If not, please fill Par-Q and proceed.

Do you now, or have you had in the past:

* Any chronic illness or condition ☐ yes ☐ no
* Muscle, joint or back disorder, or any previous injury still affecting you ☐ yes ☐ no
* Difficulty with physical exercise ☐ yes ☐ no
* Advice from physician not to exercise ☐ yes ☐ no
* History of breathing or lung problems ☐ yes ☐ no
* Thyroid condition ☐ yes ☐ no
* Cigarette smoking habit ☐ yes ☐ no
* Obesity (more than 20 percent over ideal body weight) ☐ yes ☐ no
* History of heart problems in immediate family ☐ yes ☐ no
* Hernia, or any conditions that may be aggravated by lifting weights ☐ yes ☐ no

Do you now, or have you in the past had health problems in any of the following areas?

* Diabetes	☐ yes ☐ no	* Blood pressure	☐ yes	☐ no
* Asthma	☐ yes ☐ no	* High Cholesterol	☐ yes	☐ no
* Heart	☐ yes ☐ no	* Cancer	☐ yes	☐ no
* Stroke	☐ yes ☐ no	* Surgery (recent)	☐ yes	☐ no
* Epilepsy	☐ yes ☐ no	* Fibromyalgia	☐ yes	☐ no
* Arthritis	☐ yes ☐ no	* Irritable Bowel	☐ yes	☐ no
* Pregnancy	☐ yes ☐ no	* Other		
* Environmental Sensitivities	☐ yes ☐ no	* Explain		

Are you currently taking any medications? ☐ yes ☐ no

If you checked "yes", please list medications, dosage, and for what condition

Medication_____Dosage _____ Condition

Medication _____Dosage _____ Condition

Medication_____Dosage _____ Condition

Are you currently undergoing treatment from any of the following?

* Physiotherapist ☐ yes ☐ no * Chiropractor ☐ yes ☐ no *Massage Therapist ☐ yes ☐ no

If "yes", please explain.

Insurance coverage ☐ yes ☐ no

Name of company _____Policy #_____ ID #

Physical Activity/Active Living

In the past year, how often have you participated in physical activity? Active living?
Regular (3 to 4 times per week) Semi-regular (1 to 2 times per week)___Sporadic (1 to 2 times per month)
Regular (3 to 6 weeks to drop out) Seasonal (winter or summer only) None
What types of physical activity do you like or consider "fun"?
What are your reasons for not exercising?

What physical activities have you been successful with in the past?

Support

Do you receive positive support from family, friends and co-workers toward your efforts at physical activity? ☐ yes ☐ no
Do they participate with you, or are you given the time needed to participate on your own? ☐ yes ☐ no

Occupation/Leisure

What is your present occupation?
How many hours per week?_____Are your hours flexible? ☐ yes ☐ no
Do you take time for lunch? ☐ yes ☐ no If "yes", how much time?
Does your occupation involve a lot of activity (ie. walking, up and down stairs/elevators, carrying items)?
Mode of transportation: by car ☐ yes ☐ no walk ☐ yes ☐ no bus ☐ yes ☐ no
What are your leisure activities?
How would you rate your level of stress on a daily basis?
Low_____Moderate_____High
In what ways do you deal with your stress?

Body Composition

What do you think your ideal weight should be?_____lbs/kg
Have you ever been at your ideal weight? ☐ yes ☐ no
If "yes", how long ago? Now_____ One year_____ Three years_____ Five years_____ Never

Dietary Habits

How many meals and/or snacks do you have per day?
What would you estimate your calorie intake to be per day?
Do you feel that you eat a healthy diet most of the time?
Are you currently following any type of special diet? Please check all the appropriate categories.
Reduced Calorie_____Increased Calorie_____Low Fat_____Rotation Diet
Low Cholesterol_____Low Sodium_____Candida_____Other

Rest Periods

How many hours of sleep do you average each night?
Do you feel rested upon awaking in the morning?
Do you feel you need to rest/sleep after the lunchtime meal?
Do you feel rested on the weekends, and fatigued progressively throughout the week?
_____Do you have any sleep disorder? If "yes", explain.

Are there any other reasons (health or personal) that may limit or prevent you from exercising?

Pleased be advised that certain health restrictions may require medical clearance from your Doctor before training can begin.

Signature Date