FitnessRx
BE YOUR BEST

www.fitnessrxky.com

HEALTH HISTORY & ACTIVITY QUESTIONNAIRE

Full Name

Street Address

City

State

Zip Code

Phone Number

E-mail Address

Gender ◯ Male ◯ Female DOB

EMERGENCY CONTACT INFORMATION

Contact Name

Contact Phone Number

Relationship

MEDICAL

Has a doctor or health professional ever told you that you have or have had any of the following conditions. If you have a family history of any of the conditions, please check the box:

Heart Disease
- ☐ **Yes**
- ☐ **No**
- ☐ **Family History**

Asthma
- ☐ **Yes**
- ☐ **No**
- ☐ **Family History**

High Cholesterol
- ☐ Yes
- ☐ No
- ☐ Family History

Stroke
- ☐ Yes
- ☐ No
- ☐ Family History

Diabetes
- ☐ Yes
- ☐ No
- ☐ Family History

High or Low Blood Pressure
- ☐ Yes
- ☐ No
- ☐ Family History

Emphysema
- ☐ Yes
- ☐ No
- ☐ Family History

Epilepsy
- ☐ Yes
- ☐ No
- ☐ Family History

Cancer
- ☐ Yes
- ☐ No
- ☐ Family History

Do you have any of the following?

Back Pain ☐

Joint Replacement/ Repair ☐

Tendon or Muscular Pain ☐

Pacemaker ☐

Osteoporosis ☐

Are you currently taking any medication that would affect the following?

Heart Rate
- ◯ Yes
- ◯ No

Blood Sugar
- ◯ Yes
- ◯ No

Balance
- ◯ Yes
- ◯ No

Please list any other condition or recent surgeries that you feel we should know about in planning and executing a fitness program for you:

LIFESTYLE

Which best describes your current smoking status?

- ☐ NEVER smoked
- ☐ QUIT more than 6 months ago
- ☐ CURRENTLY smoke
- ☐ QUIT within last 6 months

Do you consider yourself to be:

- ◯ Sedentary
- ◯ Mildly Active
- ◯ Active
- ◯ Very Active

If other than Sedentary, describe your current exercise level:

- ☐ Exercise 1 to 2 times per week
- ☐ Exercise 3 to 4 times per week
- ☐ Exercise 5 to 7 times per week

What type of exercise activities to you participate in regularly?

GENERAL HEALTH

Rate the following on a scale of 1 to 10 (10 being the highest level):

	1	2	3	4	5	6	7	8	9	10
Your current fitness level:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Energy level throughout the day:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Your current stress level:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
How committed are you to reaching your fitness goals?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

What is your occupation?

How many hours of sleep do you get per night?

Do you feel you are at your ideal weight?

List any allergies you have:

How many glasses of water do you drink per day?

How many caffeinated beverages do you consume per day?

Do you drink alcohol? ◯ Yes ◯ No **How many per day?** **How many per week?**

How many meals per day do you eat?

Do you eat: Breakfast? ◯ Yes ◯ No **Lunch?** ◯ Yes ◯ No **Dinner** ◯ Yes ◯ No

Please check any of the following activities you have participated in currently or in the past:

- ☐ Aerobic Training
- ☐ High Intensity Training
- ☐ Mind/Body Exercise
- ☐ Strength/Resistance Training
- ☐ Martial Arts
- ☐ Yoga
- ☐ Pilates

Team Sports (which?)

Which of these did you find successful and why?

I have read, understand and have completed this questionnaire. Any questions I have were answered to my satisfaction. ☐

I acknowledge that by typing my full name, I am signing this document. I also acknowledge that I can request a paper copy of this document and sign it instead if I choose to.

Signature **Date**

Signature of Parent/ Guardian (if under 18) **Date**