



Name: _____ Age: _____ DOB: _____
 Street Address: _____ City/State/Zip: _____
 Home Phone: _____ Cell Phone: _____
 Email Address: _____ Gender: _____
 Emergency Contact Person: _____
 Emergency Phone: _____ Relationship to Emergency Contact: _____
 Best way to contact you: Call ___ Text ___ Email ___ Today's Date ___/___/___

Health Questionnaire

1. ___ Yes ___ No Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor?
2. ___ Yes ___ No Do you feel pain in your chest when you do physical activity?
3. ___ Yes ___ No In the past month, have you had chest pain when you were not doing physical activity?
4. ___ Yes ___ No Do you lose your balance because of dizziness or do you ever lose Consciousness?
5. ___ Yes ___ No Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
6. ___ Yes ___ No Is your doctor currently prescribing drugs (for example, water pills) or your blood pressure or heart condition?
7. ___ Yes ___ No Do you know of any other reason why you should not do physical activity?
8. ___ / ___ / ___ Date of your last physical

Present/Past History

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Edema | <input type="checkbox"/> High/low blood pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart diseases | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Known heart murmur |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cancer | <input type="checkbox"/> Palpitations or tachycardia |
| <input type="checkbox"/> Recent operation | <input type="checkbox"/> Angina (Chest Pain) | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies/Sinus | <input type="checkbox"/> Abnormal ECG |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Orthopedic or muscular problems | |

If any of the above are checked, please explain and indicate any recommendations you doctor has made regarding exercise

Activity History

Do you participate in a regular exercise program or perform any recreational activities at this time? Yes No

If yes, describe and how often:

**Have you ever performed resistance/weight training exercises in the past?
 Yes No**

**Do you have injuries (bone or muscle disabilities) that may interfere with exercising?
 Yes No**

If yes, describe:

Please list any medications you are taking (including self-prescribed):

**Do you smoke? Yes No
If YES how often? _____**

**Do you drink alcohol? Yes No
If YES how often? _____**

Are there any injuries or limitations that have not been discussed up to this point?

Personal

Approximately, what is your body weight now? _____ Height: _____

What goals do you hope to achieve from your training sessions?

Do you have any special diets or nutritional habits? ___Yes ___ No

If yes, please describe:

What is your occupation? Do you sit or stand for long periods of time?

Explain. _____

Please describe your personal lifestyle (i.e.; do you have kids? what are your hobbies?) _____

How did you hear about Get Fit With Faryn?
