get fit with faryn
AN INCLUSIVE WELLNESS HAVEN

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):

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

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?

_____