StudioFit50+
937 Coffee Rd Ste 600
Modesto, CA 95355

HEALTH HISTORY QUESTIONNAIRE

ANSWER EACH QUESTION BY PRINTING THE NECESSARY INFORMATION. YOUR ANSWERS ARE CONFIDENTIAL.

PERSONAL INFORMATION

Name:	Date of Birth:	Age:
Address:		
Email Address:		
Phone:		
Employer:	Occupation	
Emergency Contact Information:		
Name:	Relationship:	
Home Phone:	Work Phone:	

MEDICAL INFORMATION

Physician:	Phone:
Are you under the care of a physician, chiropractor, or other healthcare professional for any reason? ◯Yes ◯No (If yes, please explain):	
Date of Last Physical:	
Are you taking any medications? ◯Yes ◯No (If yes, please complete the following) Type Dosage/Frequency Reason for Medication _____ _____ _____ _____ _____	
Any new changes in medication within the last 3 months? ◯Yes ◯No (If yes, please explain)	

Has your doctor ever said 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

HEALTH HISTORY QUESTIONNAIRE

MEDICAL INFORMATION, CONTINUED

Is there any reason not mentioned why you should not follow a regular exercise program?
○ Yes ○ No (If yes, please explain):

Have you recently experienced any chest pain associated with either exercise or stress?
○ Yes ○ No (If yes, please explain):

SMOKING

Please check the box that describes your current habits:

- ○ Non-user or former user; Date quit: _____
- ○ Cigar and/or pipe
- ○ 15 cigarettes or less per day
- ◉ 16 to 25 cigarettes per day
- ○ 26 to 35 cigarettes per day
- ○ More than 35 cigarettes per day

LIFESTYLE AND DIETARY FACTORS

Please fill in the information below:

Occupational Stress Level:	○ Low	○ Medium	○ High
Energy Level:	◉ Low	○ Medium	○ High

Caffeine Intake/Daily: _____ Alcohol Intake/Weekly: _____

Colds Per Year: _____

Anemia:	○ Yes	○ No
Gastrointestinal Disorder:	○ Yes	○ No
Hypoglycemia:	○ Yes	○ No
Thyroid Disorder:	○ Yes	○ No
Pre/Postnatal:	○ Yes	○ No

CARDIOVASCULAR

Please fill in the information below:

High Blood Pressure:	○ Yes	○ No	
Hypertension:	○ Yes	○ No	
High Cholesterol:	○ Yes	○ No	
Heart Disease:	○ Yes	○ No	Date: _____
Heart Attack	○ Yes	○ No	Date: _____
Stroke:	○ Yes	○ No	Date: _____
Gout:	○ Yes	○ No	

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MUSCULOSKELETAL INFORMATION

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomforts:

- ☐ Head/Neck: _____
- ☐ Upper Back: _____
- ☐ Lower Back: _____
- ☐ Arm/Elbow: _____
- ☐ Wrist/Hand: _____
- ☐ Shoulder/Clavicle: _____
- ☐ Hip/Pelvis: _____
- ☐ Thigh/Knee: _____
- ☐ Arthritis: _____
- ☐ Hernia: _____
- ☐ Surgeries: _____
- ☐ Other: _____

NUTRITIONAL INFORMATION

Are you on any specific food/diet plan at this time?	○ Yes	○ No	(If yes, please explain)
Do you take any dietary supplements?	○ Yes	○ No	(If yes, please explain)
Do you experience any frequent weight fluctuations?	○ Yes	○ No	(If yes, please explain)
Have you experienced a recent weight gain or loss? Over how long?	○ Yes	○ No	(If yes, please explain)

How many beverages do you consume per day that contain caffeine? _____

How would describe your current nutritional habits?

How would you rate your current eating habits on a scale of 1 (Worst) through 10 (Best)?	_____
How many times a week do you eat out?	_____

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EXERCISE HISTORY INFORMATION

Are you currently involved in a regular exercise program? ○ Yes ○ No

Do you regularly walk or run 1 or more mile continuously? ○ Yes ○ No

If yes, what is the average number of miles you cover in a workout? _____

Do you practice weightlifting or calisthenics?

Are you involved in a fitness program? ○ Yes ○ No

If yes, what type(s)? _____

Check all that apply:

- ☐ Golf
- ☐ Bowling
- ☐ Tennis
- ☐ Handball
- ☐ Swimming
- ☐ Hiking
- ☐ Walking/Running (outdoors)
- ☐ Stationary Running
- ☐ Bicycling (outdoors)
- ☐ Stationary Bicycling
- ☐ Other: _____

Average number of times per week: _____

WORK AND EXERCISE HABITS

Please check the box 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
- ○ Complete lack of all exertion

Are you retired? ○ Yes ○ No

If no, do you currently work more than 40 hours a week? ○ Yes ○ No

Please make any other comments you feel are pertinent to your exercise program: _____

_____

_____

_____

Name: _____ Please print to sign and date below

Signature: _____ Date: _____