PERSONAL HEALTH AND FITNESS
MEDICAL HISTORY/GOALS QUESTIONNAIRE

NAME:_____
ADDRESS_____
PHONE: WORK_____**HOME:**_____
EMAIL(S):_____
DATE:_____**DATE OF BIRTH:**_____
PRIMARY HEALTH CARE PROVIDER:_____
PROVIDER'S CONTACT NUMBER:_____
OTHER HEALTH CARE SPECIALISTS: _____
_____

Do you have regular treatment from any of the following:

- □ **Massage Therapist**
- □ **Acupuncturist**
- □ **Naturopath**
- □ **Chiropractor**
- □ **Physiotherapist**

EXISTING MEDICAL CONDITIONS: Please check all that apply.

- □ **Diabetes**
- □ **Asthma**
- □ **Heart Condition**
- □ **Epilepsy**
- □ **Hernia**
- □ **Ulcer**
- □ **Hearing Loss**
- □ **Smoker**
- □ **Thyroid Problems**
- □ **Pregnancy**
- □ **Arthritis**
- □ **Obesity**
- □ **High Cholesterol**
- □ **Anaemia**
- □ **Vision Problems**
- □ **High Blood Pressure**
- □ **Low Blood Pressure**

□ **Other Medical Conditions – please describe:**

_____
_____
_____
_____
_____
_____
_____
_____

Are you: □ Right-handed □ Left-Handed □ Ambidextrous

Alcohol Consumption: None Low Moderate Frequent

Height: _____ Current Weight: _____ Ideal Weight _____

Do you follow a special diet? Yes No If yes, describe _____

Family Health History
Has any family member died of a heart attack before age 50? If so, who?

_____

List any major illnesses your immediate family suffers from:

_____
_____

Do you have any injuries or orthopaedic problems (bad back, bad knees, tendonitis, bursitis)? If so, describe:_____

_____
_____

Are you taking any medications? Please list and describe their purpose.

_____
_____
_____
_____

Describe your current exercise program, if any:

_____
_____
_____

Can you get down to the floor and back up?
□Yes □Yes, with help □No

List your goals for your exercise program:

_____
_____
_____
_____

I acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in this exercise program.
Signed: _____ Date: _____