VIP healthcoach

HEALTH HISTORY QUESTIONNAIRE

Last Name	First Name

Address

Phone	Cell	Email

1. Have you exercised within the past 6 months? ☐ Yes ☐ No
2. Are you currently dieting? ☐ Yes ☐ No
3. Do you smoke? ☐ Yes ☐ No
   3a. If yes, how many cigarettes per day? __________
4. Do you drink alchohol? ☐ Yes ☐ No
   4a. If yes, how much per week? _____________
5. Do you drink coffee? ☐ Yes ☐ No
   5a. If yes, how many cups per day? ____________
6. Do you drink soda? ☐ Yes ☐ No
   6a. If yes, how many cans per day? ____________
7. Indicate any diseases or illnesses you have or had in the past:

☐ Asthma	☐ Allergies	☐ Arthritis	☐ Back Condition
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Bursitis	☐ Fatigue
☐ Joint Pain	☐ Ulcers	☐ Heart Condition	☐ Hemorrhoids
☐ Hernia	☐ Nervous Tension	☐ Sinus	☐ Varicose Veins
☐ Epilepsy	☐ Shortness of Breath	☐ Diabetes Type:	☐ Other

VIP healthcoach

HEALTH HISTORY QUESTIONNAIRE

8. Have you ever been hospitalized for:

- ☐ Heart attack or condition
- ☐ Chest pain / angina pectoris
- ☐ Coronary bypass / angioplasty
- ☐ Abnormal stress test
- ☐ Heart murmur
- ☐ Irregular heart beat / rythm
- ☐ Impaired circulation
- ☐ Stroke
- ☐ Convulsions
- ☐ Siezures
- ☐ Loss of consciousness
- ☐ Diabetes
- ☐ Musculoskeletal limitations of movement
- ☐ Arthritis/Rheumatism
- ☐ Knee problems
- ☐ Hip problems
- ☐ Shoulder problems
- ☐ Foot problems
- ☐ Arm problems
- ☐ Back pain lower/upper
- ☐ Swollen, stiff or painful joints
- ☐ Depression
- ☐ Sleeping Disorders
- ☐ Anxiety
- ☐ Nervousness

9. What are your Cholesterol levels?

HDL ____ LDL_____ Total ____ Ratio _______%

10. What is your normal Blood pressure? systolic ______ diastolic ______

11. Date or your last physical examination ________________

12. Doctors name _________________________ Telephone: ___________________________

I certify to the best of my knowledge the above information is correct and complete. I also understand that Henry Weber assumes no responsibility for any illness, accident or injury I may incur from the use of the program, service or facilities. All individuals are strongly encouraged to consult with a physician before entering a non –medically supervised exercise program.

Client Signature	Print Name	Date

Health History Questionnaire

I. Personal Information:

First name: ____________ ________ _
Height ________________ _
Phone (cell home / work):
____________________ ________ _
Highest education: (high school / college / graduate)
Name of physician:
phone: ______________________________ _

last name:
_
weight
_

Birthrate: ____________ _

Occupation: ___________ _

II. Additional Information:

Have you exercised within the past 6 months? Yes No
Have you previously participated in any fitness program? Yes No
Are you currently dieting? Yes No
Cigarettes smoked per week: ____________ _
Alcoholic drinks consumed per week: ______ _______ _
Cups of coffee or tea consumed per week: __ ________ __ _
Cans of soda drinks consumed per week: ___ ________ _

III. Health History Part 1: (Indicate any diseases or illnesses you have had or currently have:)

_Asthma _Back
Condition _Bursitis
_Ulcers _Hernia
_Varicose Veins
Diabetes

_Allergies
_High Blood Pressure
_Fatigue
_Heart Condition
_Nervous Tension
_Epilepsy
_HIV

_Arthritis
Low Blood Pressure
_Joint Pain
Hemorrhoids _Sinus
_Shortness of Breath
Other

IV. Health History Part 2:

(Do you have or have you ever ~ad:)
"

Have you ever been hospitalized	Yes	No
Heart Attack or Heart Trouble	Yes	No
Chest Pain or Angina Pectoris	Yes	No
Coronary Bypass or Angioplasty	Yes	No
Abnormal Exercise Stress Test?	Yes	No
Heart Murmur (suggesting a heart abnormality)	Yes	No
Irregular Heart Beat or Rhythm (suggesting a heart abnormality)	Yes	No
High Blood Pressure Above 145/95	Yes	No
Impaired Circulation	Yes	No
Stroke	Yes	No
Convulsions or Loss of Consciousness	Yes	No
Diabetes Mellitus	Yes	No
High Blood Cholesterol Level	Yes	No
If female - are you pregnant	Yes	No
Do you smoke or have you ever-used smokeless tobacco for a total of 10 years	Yes	No

Continue to page 2 ...

IV. Health History Part 2:

(Continued from the previous page)

Musculoskeletal Limitations of Movement	Yes	No
Difficulty Breathing / Shortness of Breath	Yes	No
Arthritis, Rheumatism	Yes	No
Knee Problems	Yes	No
Hip Problems	Yes	No
Shoulder Problems	Yes	No
Feet Problems	Yes	No
A chronic, recurrent or moming cough	Yes	No
Any episode of coughing up blood	Yes	No
Increased anxiety or depression Swollen,	Yes	No
stiff or painful joints	Yes	No
Back Pain (Herniated or ruptured Disc)	Yes	No
Surgery	Yes	No
Increased anxiety or depression	Yes	No

IMPORTANT: If you answered Yes to any of the previous questions, contact your physician as soon as possible.

Cholesterol Profile: HDLs _____ _ LDLs ______ Total ____ _

Blood Pressure: Systolic ___ _______ Diastolic __ ________

Are you taking any medication? Yes No

Specify Type & Dosage: ____ _______________ _

When was your last physical examination? ____ _

I certify to the best of my knowledge the above information is correct and complete. I also understand that Paul McAleavey assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program. "

Client Signature: __________________________ Date: ______________ _

Trainer Signature: ________________________ _ Date: ______________ _