



PRE-EXERCISE & HEALTH QUESTIONNAIRE

Name:		
Address:		
Phone Number:		
Email Address:		
Birth date:		
M/FM	Height:	Weight:

What specific lifestyle, health, or fitness goals are you looking to achieve here:

- | | | |
|---|--|---|
| <input type="checkbox"/> Improve my Aerobic Fitness | <input type="checkbox"/> Improve my health | <input type="checkbox"/> Maintain my health |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Strength Training | <input type="checkbox"/> Muscular Endurance |
| <input type="checkbox"/> Sports Conditioning | <input type="checkbox"/> Body Building | <input type="checkbox"/> Other_____ |

Which best describes your exercise characteristics:

- I find exercise easier to stick to if I have a partner
- I find exercise easier with some assistance
- I stick with exercise when I have constant motivation
- I am self motivated to exercise

Exercise History:

Do you have any experience using Cardio Equipment (Ex. Treadmill, bike)? Y/N

Do you have any experience using Strength Training machines? Y/N

Do you have any experience using free weights? Y/N

Do you currently exercise on a regular basis? Y/N

Type of Exercise_____ Duration_____

Intensity_____ Frequency_____

Health History:

Date of Last medical physical exam:_____

Please check any of the following for which you have been diagnosed or treated by a physician or health professional:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes/Pre-Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other_____ | |

Please Provide Details:

A family history of heart disease:_____

Any Breathing Difficulties:_____

Arthritis:_____

Any muscle or joint pain:_____

History of any major injuries/Hospitalizations:_____

Any condition that may limit your exercise program:_____

Would you like to have Fitness Assessment administered to determine your blood pressure, body fat % , and other measurements? Y/N

Would you like to work with one of our Personal Trainers? Y/N

If so, would you like to train with a: Male, Female, or either (circle one)?

✓ How did you hear about us?_____