Health Questionnaire

Personal Assessment

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Name:_____ **Date of Birth:**_____

Address:_____

Email:_____ **Mobile:**_____

Height:_____**Weight:**_____

This form is intended to obtain relevant information about your health that will assist Marie in helping you with your training programme. Please answer all questions to the best of your knowledge.

1. Weight

☐ Underweight (more than ½ stone under ideal)

☐ Normal (+ or – ½ stone of ideal)

☐ ½ stone to 1 ½ stone overweight

☐ More than 2 stone overweight

2. Blood Pressure

Do you have high blood pressure? Yes ☐ No ☐

Have you had high blood pressure in the past? Yes ☐ No ☐

Are you on medication for high blood pressure? Yes ☐ No ☐

3. Do you have a history of any of the following?

Heart disease Yes □ No □

Heart attack Yes □ No □

Stroke Yes □ No □

Elevated cholesterol Yes □ No □

Elevated triglycerides Yes □ No □

Any other vascular condition Yes □ No □

Do you have a history of Cancer? Yes □ No □ if so, which type:_____

4. Lifestyle Factors (non-diet related)

Are you a smoker? Yes ☐ No ☐

If so, how many per day, and, for how many years? _____/day for _____years

Are you a former smoker? Yes ☐ No ☐

Do you currently exercise on a regular basis? Yes ☐ No ☐

If so, describe your regular exercise routine (type of exercise, how long, times per week etc.):

_____

_____

_____

5. Health History

Have you ever had any of the following conditions? (Check mark in the box indicates yes, please check all that applies).

☐ Diabetes	☐ Asthma
☐ Overactive thyroid gland	☐ Epilepsy
☐ Underactive thyroid gland	☐ Arthritis
☐ Kidney disease	☐ Osteoporosis
☐ Liver disease	☐ Prostatitis
☐ Cushing's syndrome	☐ Gout
☐ Pancreatic disease	☐ Multiple sclerosis (MS)
☐ Gall bladder disease	☐ Lung disease (ex.emphysema, COPD)
☐ Parkinson's disease	☐ Dementia
☐ Lymphoedema	☐ Fibromyalgia

☐ Other: _____

6. Stress

What level of stress do you routinely deal with? (0 = no stress, 10 = maximum stress)

0 1 2 3 4 5 6 7 8 9 10

7. Family History

Have any of your blood relatives had heart disease, heart surgery, or angina? Yes ☐ No ☐

8. Orthopedic Problems

Do you have any serious orthopedic problems that would prevent you from exercising? Yes ☐ No ☐

If yes, please explain_____

_____

_____

9. Other problems:

Do you have any reason to believe you should not exercise? Yes ☐ No ☐

If yes, please explain_____

_____

_____

10. Medication:

Please list any medications you presently take.

_____

_____

_____

11. Wellness Goals

Indicate which health and fitness goals interest you:

☐ Weight management
☐ advice on disease prevention
☐ improved fitness
☐ anti-aging strategies
☐ increased strength and muscle mass
☐ rehabilitation of a muscle or joint injury
☐ Advice on proper, balanced nutrition
☐ supplementation advice based on my specific needs
☐ Other: _____

12. Emergency

Please list a relative whom we may contact in case of an emergency.

Name_____ Telephone:_____

Relation: _____