Lifestyle and Health- History Questionnaire

Name (last)	(first)		DOB	Age	Date
Address		City	State		Zip
❑ M ❑ F	Height	Occupation	Prim Phone	Email	
Emergency Contact			Relationship	Phone	

How would you describe your present state of health? ❑ very well ❑ healthy ❑ unhealthy ❑ ill ❑ other

Health History

1. Are you under the care of a physician, chiropractor or other health care professional for any reason? ❑ Yes ❑ No
   If yes, why? _____
2. When was the last time you visited your physician? _____
3. Are you taking any prescription medication? ❑ Yes ❑ No If yes, what and why? _____
   Do these interact with foods or weight loss in any way? ❑ Yes ❑ No If yes, how? _____
4. Do you take any over-the-counter medication? ❑ Yes ❑ No If yes, what and why? _____
5. Do you take any vitamin, mineral, or herbal supplements? ❑ Yes ❑ No
   Please list type and amount per day: _____
6. Please check any that apply to you and list any important information about your condition:

❑ Allergies _____
❑ Amenorrhea
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Celiac disease
❑ Chronic sinus condition
❑ Constipation
❑ Crohn's Disease
❑ Depression
❑ Diabetes
❑ Diarrhea
❑ Disordered eating
❑ Gastroesophageal reflux disease
❑ High blood pressure
❑ Hypoglycemia
❑ Hypo/hyperthyroidism
❑ Insomnia
❑ Intestinal problems
❑ Irritability
❑ Irritable bowel syndrome (IBS)
❑ Menopausal symptom
❑ Osteoporosis
❑ Premenstrual syndrome (PMS)
❑ Polycystic ovary syndrome (PCOS)
❑ Pregnant
❑ Ulcer
❑ Skin problems
❑ Major surgeries:
❑ Past injuries: _____
❑ Describe any other health conditions that you have:
_____
_____

Weight & Nutrition

7. What would you like to do with your weight? ❑ lose weight ❑ gain weight ❑ maintain weight
8. What was your lowest weight within the past 5 years? _____ lbs. Highest weight? _____ lbs.
9. What do you consider to be your ideal weight (the weight at which you feel best)? _____ lbs. ❑ I don't know
10. What is your present weight? _____ lbs. ❑ I don't know
11. What, if any, are your dietary goals? _____

12. Have you ever followed a modified diet? ❑ Yes ❑ No
    If so, describe: _____
13. What do you consider, if any, to be the major issues in your diet and eating plan? (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety) _____
14. How often do you dine out? _____ times per week
15. Do you crave any foods? ❑ Yes ❑ No If so, please specify: _____
16. How is your appetite affected by stress? ❑ increased ❑ not affected ❑ decreased
17. How many glasses of water do you drink per day? _____ 8-ounce glasses
18. Do you drink alcohol? ❑ Yes ❑ No How often? _____ Times/week How much? _____ glasses
19. Do you drink caffeinated beverages? ❑ Yes ❑ No Average number per day: _____

Lifestyle

20. Do you use tobacco? ❑ Yes ❑ No How much (cigarettes, cigars, or chewing tobacco per day)? _____
21. To what degree do you consider your environment stressful? ❑ Minimal ❑ Moderate ❑ Average ❑ Extremely
22. What are your leisure activities? _____
23. Please describe your activity level during the workday: ❑ Sedentary ❑ Lightly Active ❑ Active ❑ Very Active
24. Please describe your current exercise regimen:
    ❑ Sedentary (no exercise) ❑ Lightly Active (1-2x/week) ❑ Active (3-4x/week) ❑ Very Active (5+/week)
25. Is your spouse or a close friend involved in any regular physical activity? ❑ Yes ❑ No
26. Have you experienced any injuries that may limit your physical activity? If so, please describe...

Head/Neck _____ Upper Back _____ Shoulder/Clavicle _____

Arm/Elbow _____ Wrist/Hand _____ Lower Back _____

Hip/Pelvis _____ Thigh/Knee _____ Lower Leg/Ankle/Foot _____

27. Do you have any negative feelings toward, or have you had any bad experience with physical activity programs?
    If so, please specify: _____
28. Do you have any negative feelings toward, or have you had any bad experience with fitness testing and evaluations?
    If so, please specify: _____
29. Do you start exercise programs but then find yourself unable to stick with them? ❑ Yes ❑ No
    If so, what are the barriers: _____
30. How much time are you willing to devote to an exercise program? _____ min/day _____ days/week
31. What physical activity have you been successful with in the past (liked and participated in regularly)?
    _____
32. What types of exercise interest you? ❑ walking ❑ jogging ❑ swimming ❑ cycling ❑ racquet sports ❑ elliptical
    ❑ stair climbing ❑ other cardio activity ❑ yoga/pilates ❑ weight training
33. What are your primary goals? Please be specific? (ie, strength, flexibility, function, weight loss, muscle gain)
    1. _____ 2. _____
    3. _____ 4. _____
34. On a scale of 1–10, how ready are you to adopt a healthier lifestyle? 1 = very unlikely 10 = very likely _____

Physical Activity Readiness Questionnaire (PAR-Q) and You

Regular physical activity is fun and healthy, and people are becoming more active every day. Being more active is very safe for most people. However, some people should check with their doctor before increasing their level of physical activity. If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below.

YES	NO	
❑	❑	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
❑	❑	2. Do you feel pain in your chest when you do physical activity?
❑	❑	3. In the past month, have you had chest pain when you were not doing physical activity?
❑	❑	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
❑	❑	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
❑	❑	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
❑	❑	7. Do you know of <u>any other reason</u> why you should not do physical activity?

If You Answered:	YES to one or more questions
	Talk to your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES. • You may be able to do any activity you want – as long as you start slowly and build up gradually. OR, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice. • Find out which community programs are safe and helpful for you.
No to all questions	If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can: • Start becoming much more physically active- begin slowly and build up gradually. This is the safest and easiest way to go. • Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. Delay becoming much more active: • If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or • If you are or may be pregnant – talk to your doctor before you start becoming more active. Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

History (check all that apply)

- ❑ heart attack
- ❑ heart surgery
- ❑ heart transplantation
- ❑ coronary angioplasty (PTCA)
- ❑ heart failure
- ❑ heart valve disease
- ❑ congenital heart disease

Other Health Issues (check all that apply)

- ❑ diabetes
- ❑ asthma
- ❑ lung disease
- ❑ claudication
- ❑ thyroid disease
- ❑ liver or kidney disease
- ❑ pregnant
- ❑ prescription medications
- ❑ musculoskeletal problems that limit your physical activity

ACSM major coronary risk factors: (check all that apply)

- ❑ Lipids (TCH > 200 OR HDL < 40)
- ❑ Cigarette Smoking (or quit within the past 6 months)
- ❑ Family History of Immediate family member with
- ❑ High Blood Pressure/Blood Pressure medications
- ❑ Diabetes/glucose > 110 mg/dl
- ❑ Sedentary
- ❑ BMI ≥ 30
- ❑ Signs or Symptoms of Cardiovascular Disease_____
- ❑ Cardiovascular Disease_____
- ❑ Pregnancy
- ❑ Age (Male > 45; Female > 55)

For Use by the Personal Trainer ONLY

Risk Stratification		Factors
_____	Low Risk	One or No Risk Factors/Asymptomatic (No medical clearance required)
_____	Moderate Risk	Two or More Risk Factors/Asymptomatic (Medical clearance required)
_____	High Risk	Diagnosed Cardiopulmonary/Metabolic Disease/Symptomatic (Annual medical clearance required)
_____	Pregnancy	Medical Clearance Required

It is your responsibility to inform us if your health condition changes.

"I have read, understood and completed the questionnaire. Any questions I had were answered to my full satisfaction."

Name: _____ Signature _____ Date____/____/_____

Signature of Parent or Guardian (for participants under the age of 18):_____ Trainer_____

For Emergency Purposes:

Physician(s):_____ Preferred Hospital_____

Limitations and/or Medications:_____

Waiver of Liability

I wish to participate in PERSONAL TRAINING ("Program") offered by BODY SHOPPE FITNESS, LLC ("Facility"). As a participant of BODY SHOPPE FITNESS, LLC, I represent and agree as follows:

1. As required for participation in the Program, I have completed a Physical Activity Readiness Questionnaire (if applicable) and have if required, submitted a Medical Clearance Form and any additional medical test results and/or forms as may be required of me to the Facility. _____(*initial*)

2. I understand the nature and purpose of the Program and am aware that any strenuous physical activity involves certain risks. I assume the risk of any and all accidents or injuries of any kind, which may be sustained by me by reason of or in connection with my participation in the Program. I release, discharge and absolve BODY SHOPPE FITNESS, LLC, its officers, directors, employees, its parties, and agents and each of their affiliates, and subsidiaries from any and all liability or responsibility for any such accident or injury. This release shall be binding upon my heirs, executors, administrators and assigns. _____ (*initial*)

3. I understand that BODY SHOPPE FITNESS, LLC is the sole manager and operator of the Program and equipment and that The Facility exercises control over the management or operation of the Program or the equipment. _____ (*initial*)

4. I agree to abide by all rules and regulations of the Program and Facility and as same may be changed from time to time. _____ (*initial*)

5. I understand BODY SHOPPE FITNESS, LLC and Parties shall not be liable for the disappearance, loss or theft of, or damage to, any of my personal property (including any personal property stored by me in any dressing room or "lock box" located in any changing room) including, but not limited to, money, negotiable securities, jewelry, clothing and etc. _____ (*initial*)

I have read this Waiver and understand all its terms. I execute it voluntarily and with full knowledge of its significance and fully understand that by agreeing to it, I am giving up legal rights and/or remedies that may be available to me. By signing below I accept the terms and conditions of membership and billing and agree to the Policies and Procedures.

NAME: _____

SIGNATURE: _____

DATE: _____ Phone #: _____ Email_____

ASSOCIATION OF FITNESS STUDIOS