Fitness 101
7107 FM 2920 Rd. Ste. 400B
Spring, TX 77379

Health/Medical Questionnaire

Date_____

Name_____ Age_____ Birth Date_____

Address_____
Street *City* *State* *Zip*

Phone (H)_____ (C)_____

(W)_____

Email Address_____

In case of emergency, whom may we contact?

Name_____ Relationship_____

Phone (H)_____ (C)_____

(W)_____

Past History: Have you had OR do you presently have any of these conditions? (Check if Yes)

Rheumatic Fever	( )	Recent Operations	( )	Edema (swelling of ankles)	( )
High Blood Pressure	( )	Injury to Back or Knees	( )	Seizures	( )
Low Blood Pressure	( )	Heart Attack	( )	Fainting	( )
Lung Disease	( )	High Cholesterol	( )	Other	( )
Diabetes	( )				
Chest Pains	( )				

Family History: Have any relatives had OR do any relatives currently have any of these conditions? (Check if Yes)

Heart Attack	( )	High Blood Pressure	( )	Diabetes	( )
Heart Operation	( )	Other Major Illness		Congenital Heart Disease	( )
High Cholesterol	( )	_____	( )		

Explain Checked Items_____

_____

_____

_____

*Office Use: Email*_____ *MindBody*_____

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Activity History

1. How were you referred to this program? (please be specific)_____

_____

_____

2. Why are you enrolling in this program? (please be specific)_____

_____

_____

3. Are you presently employed? YES _____ NO _____
4. What is your present occupational position? _____
5. Name of company _____
6. Are you currently a student? YES _____ NO _____
7. Do you participate in a regular exercise program at this time? YES _____ NO _____
   If yes, briefly describe_____

   _____

8. Do you take your pulse at any point during the exercise program?
   YES _____ NO _____
9. How high does your pulse rate reach (per minute)? _____
10. Do you have injuries (bone or muscle disabilities) that may interfere with exercising?
    YES _____ NO _____
    If yes, briefly describe _____

    _____

    _____

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11. Smoking

Do you smoke? YES _____ NO _____

If yes, how much per day and age when you started?

_____ a day _____ age

12. Weight

Are you presently involved in a weight management program?

If yes, briefly describe _____

_____

13. Medication

Name your present medications _____

_____

14. List in order your personal fitness objectives.

1. _____
2. _____
3. _____

15. Are you interested in nutritional counseling? YES _____ NO _____