HEALTH HISTORY QUESTIONNAIRE

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Please complete this questionnaire accurately and completely. The information provided is used to understand your health history, identify factors that may affect participation in physical activity, and support appropriate exercise planning.

CLIENT INFORMATION

Full Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Date Completed: _____

CURRENT HEALTH

How would you describe your current health? ■ Excellent ■ Very Good ■ Good ■ Fair ■ Poor

Have you experienced any significant change in your health during the past 12 months? ■ No ■ Yes — Please explain:

_____

_____

MEDICAL HISTORY

Condition	No	Yes	Details / Date
Heart disease or cardiovascular condition	■	■	_____
High blood pressure	■	■	_____
High cholesterol	■	■	_____
Diabetes / prediabetes	■	■	_____
Stroke / TIA	■	■	_____
Respiratory condition	■	■	_____
Asthma	■	■	_____
Kidney disease or condition	■	■	_____
Liver disease or condition	■	■	_____
Bone or joint condition	■	■	_____
Osteoporosis / low bone density	■	■	_____
Arthritis	■	■	_____
Back or spinal condition	■	■	_____
Neurological condition	■	■	_____
Thyroid condition	■	■	_____
Cancer	■	■	_____
Other significant medical condition	■	■	_____

Please describe any condition marked "Yes":

_____

_____

SURGERIES & HOSPITALIZATIONS

Have you ever had surgery or been hospitalized for a significant medical condition or injury? ■ No ■ Yes

If yes, please provide the type of surgery or reason for hospitalization and approximate date:

_____

_____

INJURIES & MUSCULOSKELETAL HISTORY

■ Back pain or injury
■ Neck pain or injury
■ Shoulder injury
■ Elbow or wrist injury
■ Hip injury
■ Knee injury
■ Ankle or foot injury
■ Fracture
■ Joint replacement
■ Chronic pain
■ Other significant injury

Please provide details, including current limitations if applicable:

_____

_____

CURRENT SYMPTOMS

■ Chest pain or pressure
■ Unusual shortness of breath
■ Dizziness or lightheadedness
■ Fainting or loss of consciousness
■ Unusual fatigue
■ Heart palpitations
■ Swelling of the legs or ankles
■ Unexplained pain
■ Other concerning symptoms

If yes, please explain:

_____

_____

MEDICATIONS & SUPPLEMENTS

Are you currently taking prescription or over-the-counter medications? ■ No ■ Yes

Please list medications and their purpose:

Medication	Purpose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you regularly use vitamins, minerals, supplements, or other nutritional products? ■ No ■ Yes

Please list: _____

_____

ALLERGIES

Do you have any known allergies? ■ No ■ Yes

Medications: _____

Foods: _____

Environmental: _____

Other: _____

FAMILY HEALTH HISTORY

■ Heart disease
■ High blood pressure
■ Stroke
■ Diabetes
■ High cholesterol
■ Osteoporosis

■ Other significant hereditary condition

Please provide relevant details:

_____

_____

PHYSICAL ACTIVITY & EXERCISE HISTORY

Are you currently physically active? ■ No ■ Occasionally ■ Regularly ■ Very regularly

Current activities:

_____

How many days per week do you typically exercise? ■ 0 ■ 1–2 ■ 3–4 ■ 5+

Approximately how long is each exercise session? ■ Less than 20 minutes ■ 20–30 minutes ■ 31–45 minutes ■ 46–60 minutes ■ More than 60 minutes

PREVIOUS EXERCISE EXPERIENCE

■ Personal training

■ Cardiovascular exercise

■ Walking / hiking

■ Cycling

■ Yoga / stretching

■ Other

■ Strength training

■ Group fitness classes

■ Running / jogging

■ Swimming

■ Sports

Please describe your previous exercise experience:

_____

_____

EXERCISE LIMITATIONS

Is there anything that currently prevents you from performing certain exercises or physical activities? ■ No ■ Yes

Please describe:

_____

Are there any exercises or activities you have been advised to avoid? ■ No ■ Yes

Please explain:

_____

SLEEP & RECOVERY

Average hours of sleep per night: ■ Less than 5 ■ 5–6 ■ 7–8 ■ 9+

How would you describe your typical sleep quality? ■ Excellent ■ Good ■ Fair ■ Poor

Do you regularly experience difficulty recovering from physical activity? ■ No ■ Yes

Details: _____

HEALTHCARE PROVIDER

Primary Healthcare Provider: _____

Provider Phone: _____

Date of Most Recent Physical Examination: _____

Is there anything your healthcare provider has specifically recommended regarding physical activity or exercise? ■ No ■ Yes

Please explain:

_____

ADDITIONAL INFORMATION

Please provide any other health information, medical history, physical limitations, or concerns that may be relevant to your participation in personal training:

_____

_____

CLIENT ACKNOWLEDGMENT

I certify that the information provided in this Health History Questionnaire is accurate and complete to the best of my knowledge. I understand that I am responsible for informing **Laura Artman, CPT LE** of any changes to my health, medications, physical condition, or ability to participate in exercise.

I understand that this questionnaire is used for fitness-program planning and does not constitute medical diagnosis or medical advice.

Client Name: _____

Client Signature: _____ **Date:** _____

Trainer Review: _____

Trainer Signature: _____ **Date:** _____