Ray & Joan KROC Corps Community Center Quincy, IL

Health History Questionnaire

For use with Fitness Assessments and Personal Training

Please respond to the following items to the best of your ability.
This information will be used by the evaluator to ensure a safe exercise environment.
All information will remain confidential unless further professional consultation seems warranted.

Name: _____ **Date:** _____

Home Address: _____

City:_____ **State:**_____ **Zip:**_____ **Email:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: ____/____/_____ **Age:**_____ **Sex:** ❒ M ❒ F

Membership Status: ❒ Gold Member ❒ Silver Member ❒ Non-Member

How did you hear about this program?

❒ Staff Member ❒ Flyer ❒ Website ❒ Friend ❒ Other _____

Individual to be contacted in the event of an emergency: _____

Relationship to you: _____ **Phone:** _____

Address: _____

Personal Physician:_____ **Physician's Phone:** _____

Physician's Address:_____

Do you have medical alert identification? _____ ❒ Yes ❒ No

If yes, where is it located? _____

Please list all medications that you are currently taking.

Name of Drug	*Dosage/Frequency*	*Reason for Taking*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How long has it been since your last physical examination?
❒ Less than 1 year ❒ 1-2 years ❒ 2-3 years ❒ 3 or more years

Please list any limitations your physician or physical therapist have given you: _____

_____

_____

_____

_____

Please indicate if you have had, or presently have, any of the following:

- ❒ Heart attack/heart disease
- ❒ Heart surgery
- ❒ Heart failure
- ❒ Heart valve disease
- ❒ Heart murmur
- ❒ Coronary angioplasty (PTCA)
- ❒ Angina (chest pain)
- ❒ Pacemaker
- ❒ Heart Transplantation
- ❒ Congenital Heart Disease
- ❒ Dizziness, fainting, or blackouts
- ❒ Unusual shortness of breath
- ❒ Chest discomfort with exertion
- ❒ Diabetes
- ❒ Phlebitis (inflammation of a vein)
- ❒ Emboli (blood clot)
- ❒ Cancer
- ❒ Stroke
- ❒ Asthma/other lung disease
- ❒ Emphysema
- ❒ Leg burning/cramping when walking short distances
- ❒ Musculoskeletal problems that limit activity
- ❒ Recent hospitalization
- ❒ Concerns about the safety of exercise

If you checked *one or more* of the above boxes, the Kroc Center Fitness & Wellness Specialist may seek your physician's clearance before you may begin working with a Personal Trainer.

Please indicate if the following applies to you:

- ❒ You are a *man* older than 45 years
- ❒ You are a *woman* older than 55 years, have had a hysterectomy, or are postmenopausal
- ❒ You currently smoke, or quit smoking within the previous 6 months
- ❒ You have high blood pressure
- ❒ You take blood pressure medication
- ❒ You have high blood cholesterol
- ❒ You have a close blood relative who had a heart attack or heart surgery before age 55 (father/brother) or age 65 (mother/sister)
- ❒ You are physically inactive (less than30 minutes of physical activity more than 3 days per week)
- ❒ You frequently experience back/neck pain
- ❒ You are >20 pounds overweight

If you checked *two or more* of the above boxes, the Kroc Center Fitness & Wellness Specialist may seek your physician's clearance before you may begin working with a Personal Trainer.

Are you, or may you be pregnant? ❒ Yes ❒ No

Describe any surgery that you have had within the last two years: _____

_____

_____

Have you ever sustained any injury or experienced any type of chronic pain which has been diagnosed as due to physical activity or sports participation? ❒ Yes ❒ No

If Yes, please explain: _____

_____

Has your weight ever fluctuated more than a few pounds? ❒ Yes ❒ No

If Yes, please explain: _____

_____

This Health History Questionnaire follows the American College of Sports Medicine (ACSM) recommendations for risk stratification. This must be performed on all clients in order to determine the need for medical clearance and/or exercise modifications. Any trainer or those making exercise recommendations should be certified in the proper use of the risk stratification process through a national organization.

Fitness Goals

Please indicate your *top three* fitness goals.

___ Improve strength
___ Improve muscle tone & shape
___ Improve cardiovascular fitness
___ Improve flexibility
___ Lose weight/decrease body fat
___ Gain weight
___ Improve diet/eating habits
___ Improve health
___ Reduce cholesterol
___ Reduce blood pressure
___ Increase energy
___ Reduce stress
___ Prevent injury
___ Rehabilitate injury
___ Train for a sports-specific event
___ Other_____

Personal Trainer Preference

❒ Male ❒ Female ❒ No preference Trainer Requested: _____

Time Preference

❒Early Morning ❒Mid-Morning ❒Lunch Time ❒Afternoon ❒Evening

I have answered the Health History Questionnaire questions accurately and completely to the best of my knowledge. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that the information I have provided will be maintained in my membership profile for use in case of a medical emergency. I understand that certain medical or physical conditions which are known to me, but that I do not disclose, may result in serious injury to me. If any of the above information changes, I agree to submit these changes in writing to this facility's Fitness & Wellness Specialist to update my membership profile. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete, and updated information in accordance with the attached questionnaire. Any information left unanswered was done so intentionally. I also understand that in order to properly risk stratify my Health History Questionnaire my trainer should have a minimum of a national certification as a personal trainer.

Should I choose to participate in the Kroc Center's Personal Training program I understand that pre-payment is required for all training sessions. I agree that I should arrive on time for training sessions and be ready to go. I understand that a 24-hour notice is required to cancel a session. If notice is not given, the session will be deducted from my current package or payment for the missed session will be required before my personal training sessions may continue. All sessions will start and end at the scheduled time. All Personal Training packages or sessions are non-transferrable and non-refundable (unless a medical excuse is provided by doctor). I understand that all sessions/packages expire one calendar year from the purchase date.

My signature signifies that I understand and agree to all of the above statements.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if individual is under the age of 18)