

Physical Health & Lifestyle Questionnaire

Name: _____ **Phone number:** _____
Gender: male/female **Birth date:** _____
Physician: _____ **Emergency Contact:** _____
Email address: _____

Are you taking any medications (prescriptions or non-prescriptions)?

Is your Doctor aware of your intentions to participate in an exercise program?

Has your Doctor ever told you not to exercise?

How many hours of sleep do you get each night?

In general how would you describe your current state of health?

Very Good Good Average Poor Very Poor

Do you have any history of the following?

Heart problem, chest pain or stroke?

Chronic illness or condition?

Recent surgery (last 3 months)?

Breathing or lung problems? Asthma?

Diabetes or thyroid condition?

Muscle pain or back disorder?

Any previous injury affecting you?

Do you have a seizure disorder? (E.g. epilepsy)

Do you have high blood pressure (hypertension)?

Is your level of cholesterol known to be high?

Do you smoke regularly? If so, how many per day?

Any other health conditions that may affect your physical fitness?

Physical Activity

Do you currently participate in any fitness activities? If so how often?

What are your personal barriers to exercise (i.e. your reasons for not exercising)?

What physical activity have you been successful with in the past (liked and participated in regularly)?

Do you want to lose weight? If so how much?

What is your past experience with fitness and /or weight training?

What are your health and fitness goals and expectations?

What is your time commitment per week? Do you prefer free weights or machines?

Dietary Patterns

How many meals and/or snacks do you have per day?

What would you estimate your daily caloric intake to be per day?

Waiver

This Document is a release of claims and by signing below, you;

- Represent to Pursuit Fitness and Bobbi Lee that you are in good health and physical condition,

Name: _____

Signature: _____

Witness: _____

Date: _____