Tru2Fitness.com
Personal Training Health Questionnaire

This form is to help us determine your readiness to begin a Personal Training Program. Information that you provide on this form will be maintained in a confidential manner and disclosed only to the Tru2Fitness Staff. With your authorization, this information may also be provided to your Physician should your answers reflect the need for your Physicians attention and/or care.

Name:_____

Date of Birth:_____Age:_____ Sex: M / F

Please complete this form to the he best of your knowledge with **Yes** or **No** answers. If you answer **Yes,** please provide explanations and specifics regarding the condition/situation.

1. Have you had a Heart Attack, Stroke, Chest Pain, or Heart Surgery?
2. Has your Doctor said that you have Cardiovascular, Pulmonary, Metabolic or other significant disease?
3. During or right after exercise, do you have any pains or pressure in the Chest area, Neck, Shoulder, or Arm?
4. Have you experienced any unusual Leg pain upon exertion?
5. Has your Doctor said that you have a Heart Murmur or Irregular Heart beat?
6. Do you have Insulin-Dependent Diabetes or take Medication to control your blood sugar?
7. Do you experience Shortness of Breath at rest or with mild exertion?
8. Has your Doctor said you have High Blood Pressure (140/90) or are you on Medication for your blood pressure?
9. Do you experience Dizziness/Fainting Spells at rest or with exertion?
10. Are you currently Pregnant or within six weeks Postpartum? (# of months pregnant)

11. Are you currently taking Prescription Medication for an underlying disorder?

12. Do you have a Chronic or Acute Orthopedic Condition, or any other health condition that you or your Physician feel will be affected by, or affect your exercise (i.e. Bursitis, Arthritis, Neck or Back Injury, Past Surgery, etc.) Please specify.

13. Do you have a medical condition not mentioned here, which might affect your ability to participate in an exercise program (i.e. Seizures, Epilepsy, Emphysema, Asthma, etc.) Please specify.

14. Do you have a male family member under the age of 55 or a female family member under the age of 65 who has a history of Cardiovascular Disease, such as Heart Disease, Stroke, Angina (chest pain), High Blood Pressure, etc.? Please specify.

15. Do you consider yourself more than 20 lbs. overweight?

16. Is your total Serum Cholesterol higher that 200 mg/di and /or have you been diagnosed with High Cholesterol?

17. Do you use tobacco or have you used tobacco within the last 5 years?

18. Are you physically inactive (less than 3 days per week or physical activity?

19. Please list any Cardiovascular, Pulmonary, Nervous System, or any related Medication that could impact how the blood responds to exercise.

20. When was your last Physical Exam?

21. Do you have any limitations not previously discusses (i.e. recent injuries, etc.)?

22. Please list any other pertinent health/medical information we should be aware of:

I understand that this form is not intended as a substitute for consultation with my Physician. I must consult with my Physician for any evaluation of my health status.

I certify that I have read and understand all questions on this health and exercise history questionnaire, and that all my questions have been answered truthfully to the best of my knowledge. I agree to notify my Personal Trainer if there are any changes in the information that I have provided herein.

Signature:_____Date:_____