Health Questionnaire

Please complete this form before your first training session. Your answers help me train you safely and effectively. All information is confidential.

Personal Information

Full name

Date of birth

Phone

Email

Emergency contact (name & phone)

General Health

[ ] Yes [ ] No — Has a doctor ever said you have a heart condition and should only do physical activity recommended by a doctor?

[ ] Yes [ ] No — Do you feel pain in your chest when you do physical activity?

[ ] Yes [ ] No — In the past month, have you had chest pain when not doing physical activity?

[ ] Yes [ ] No — Do you lose balance because of dizziness or ever lose consciousness?

[ ] Yes [ ] No — Do you have a bone or joint problem that could be made worse by exercise?

[ ] Yes [ ] No — Is a doctor currently prescribing medication for blood pressure or a heart condition?

[ ] Yes [ ] No — Do you know of any other reason you should not do physical activity?

Medical History

Current medical conditions or diagnoses

Past surgeries or hospitalizations (with dates)

Current medications & supplements

Allergies

Injuries & Pain

Current or recent injuries (last 12 months)

Chronic pain areas (neck, back, shoulders, knees, etc.)

Movements that cause pain or discomfort

Lifestyle

Current activity level & typical weekly exercise

Occupation (sitting / standing / physical)

Average sleep per night

Stress level (1–10) and main stressors

Nutrition — typical day of eating

Water intake per day

Alcohol / tobacco / recreational substance use

Training Goals

Primary goal for training

Anything else I should know before we train together?

Consent

I confirm the information above is accurate to the best of my knowledge and I will notify my trainer of any changes to my health.

Signature

Date