

**Lenexa Strength and Fitness**

**► Health History Questionnaire**

**ANSWER EACH QUESTION BY PRINTING THE NECESSARY INFORMATION. YOUR ANSWERS ARE CONFIDENTIAL.**

Name:		Date of Birth:	Age:
Address:			
City, State, Zip:		E-mail:	
Home Phone:		Work Phone:	
Employer:		Occupation:	
In case of emergency, please notify:			
Name:		Relationship:	
Address:			
City, State, Zip:			
Home Phone:		Work Phone:	

**MEDICAL INFORMATION**

Physician:		Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason? If yes, list reason:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any medications? <i>(If yes, complete the following)</i>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type:	Dosage/Frequency:	Reason for Taking:	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Please list any allergies:			
Has your doctor ever said your blood pressure was too high?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you over the age of 65?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you unaccustomed to vigorous exercise?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

► **Health History Questionnaire**

**MEDICAL INFORMATION, CONTINUED**

Is there any reason not mentioned why you should not follow a regular exercise program?  Yes  No  
 If yes, please explain: \_\_\_\_\_

Have you recently experienced any chest pain associated with either exercise or stress?  Yes  No  
 If yes, please explain: \_\_\_\_\_

**SMOKING**

Please check the box that describes your current habits:

- Non-user of former user; Date quit: \_\_\_\_\_
- Cigar and/or pipe
- 15 or less cigarettes per day
- 16 to 25 cigarettes per day
- 26 to 35 cigarettes per day
- More than 35 cigarettes per day

**FAMILY AND PERSONAL MEDICAL HISTORY**

If there is family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

- Asthma: \_\_\_\_\_
- Respiratory/Pulmonary Conditions: \_\_\_\_\_
- Diabetes: Type I: \_\_\_\_\_ Type II: \_\_\_\_\_ How Long? \_\_\_\_\_
- Epilepsy: Petite Mal: \_\_\_\_\_ Grand Mal: \_\_\_\_\_ Other: \_\_\_\_\_
- Osteoporosis: \_\_\_\_\_

**LIFESTYLE AND DIETARY FACTORS**

Please fill in the information below:

- Occupational Stress Level:  Low /  Medium /  High
- Energy Level:  Low /  Medium /  High
- Caffeine Intake/Daily: \_\_\_\_\_  Alcohol Intake/Weekly: \_\_\_\_\_
- Colds Per Year: \_\_\_\_\_  Anemia: \_\_\_\_\_
- Gastrointestinal Disorder: \_\_\_\_\_
- Hypoglycemia: \_\_\_\_\_
- Thyroid Disorder: \_\_\_\_\_
- Pre/Postnatal: \_\_\_\_\_

**CARDIOVASCULAR**

Please fill in the information below:

- High Blood Pressure: \_\_\_\_\_  Hypertension: \_\_\_\_\_
- High Cholesterol: \_\_\_\_\_
- Hyperlipidemia: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_
- Heart Attack: \_\_\_\_\_  Stroke: \_\_\_\_\_
- Angina: \_\_\_\_\_  Gout: \_\_\_\_\_

► **Health History Questionnaire**

**FAMILY AND PERSONAL MEDICAL HISTORY, CONTINUED**

**MUSCULOSKELETAL INFORMATION**

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

- Head/Neck: \_\_\_\_\_
- Upper Back: \_\_\_\_\_
- Shoulder/Clavicle: \_\_\_\_\_
- Arm/Elbow: \_\_\_\_\_
- Wrist/Hand: \_\_\_\_\_
- Lower Back: \_\_\_\_\_
- Hip/Pelvis: \_\_\_\_\_
- Thigh/Knee: \_\_\_\_\_
- Arthritis: \_\_\_\_\_
- Hernia: \_\_\_\_\_
- Surgeries: \_\_\_\_\_
- Other: \_\_\_\_\_

**NUTRITIONAL INFORMATION**

Are you on any specific food/diet plan at this time?  Yes  No  
 If yes, please list: \_\_\_\_\_

Do you take dietary supplements?  Yes  No  
 If yes, please list: \_\_\_\_\_

Do you experience any frequent weight fluctuations?  Yes  No

Have you experienced a recent weight gain or loss?  Yes  No  
 If yes, list change: \_\_\_\_\_

Over how long? \_\_\_\_\_

How many beverages do you consume per day that contain caffeine? \_\_\_\_\_

How would you describe your current nutritional habits? \_\_\_\_\_

Other food/nutritional issues you want to include (*food allergies, mealtimes, etc.*) \_\_\_\_\_



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**WORK AND EXERCISE HABITS**

Please check the box that best describes your work and exercise Habits.

- Intense occupational and recreational exertion
- Moderate occupational and recreational exertion
- Sedentary occupational and intense recreational exertion
- Sedentary occupational and moderate recreational exertion
- Sedentary occupational and light recreational exertion
- Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Work:  Minimal  Moderate  Average  Extremely

Home:  Minimal  Moderate  Average  Extremely

Do you work more than 40 hours a week?

Yes

No

Please make any other comments you feel are pertinent to your exercise program.

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**NOTE:** Please address any health concerns you have indicated on this questionnaire with your physician prior to participating in our evaluation and exercise program. Please document in writing any guidelines or limitations given to you by your physician and attach it to the Informed Consent Form. Thank you!

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF PARENT: \_\_\_\_\_  
or GUARDIAN (for participants under the age of majority)

WITNESS: \_\_\_\_\_