

## UMF FRC Health History and Fitness Goals

Your personal information will be treated with confidentiality. It will only be seen by your trainer and your trainer's immediate supervisor. If they determine that a medical clearance is needed, permission to share health information with your physician may be requested.

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_  
Date \_\_\_\_\_ Phone# daytime \_\_\_\_\_ evening \_\_\_\_\_  
e-mail \_\_\_\_\_  
Address: \_\_\_\_\_

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Please answer the following questions:

What is your occupation? \_\_\_\_\_

How physically active does it require you to be? (circle one)

Not at all    A little    Moderate    Very active    Intensely active

Rate your leisure time activity in the same way. (circle one)

Not at all    A little    Moderate    Very active    Intensely active

What physical activities have you participated in over the past year, and how frequently? (Example: Walking, daily. Skiing, twice last winter.)

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What physical activities do you enjoy? \_\_\_\_\_

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What physical activities do you dislike?

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What activities have you never tried but would like to try?

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How would you describe your present fitness level?

Poor Fair Average Good Excellent

Briefly list the goals you hope to achieve through the services of a personal trainer \_\_\_\_\_  
\_\_\_\_\_

Have you already tried to achieve any of these goals? If so, briefly describe how.  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any exercise equipment at home? If so, please list.  
\_\_\_\_\_  
\_\_\_\_\_

Complete the following sentences:

*When I start an exercise program I usually* \_\_\_\_\_

*If I stop exercising it is usually because*  
\_\_\_\_\_  
\_\_\_\_\_

*I like* (circle as many as apply): structure routine variety  
exercise that challenges my mind exercise that I don't have to think about  
surprises feeling as if I have worked very hard feeling relaxed

Do you smoke? \_\_\_\_\_ How long? \_\_\_\_\_ How much daily \_\_\_\_\_?

If you smoke, do you wish to quit? \_\_\_\_\_

Have you smoked in the past? How long? \_\_\_\_\_ How much daily \_\_\_\_\_?

Quit when? \_\_\_\_\_

Are you interested in improving how you eat? \_\_\_\_\_

Do you feel that you need to lose weight? \_\_\_\_\_ Gain weight? \_\_\_\_\_

If so, estimate the general range of pounds \_\_\_\_\_

**Personal Health History**

Diabetes	Yes	No
Heart disease or heart attack	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Chest pains, or chest pains on exertion	Yes	No
Shortness of breath at rest	Yes	No
Shortness of breath after climbing 2 flights stairs	Yes	No
Daily coughing	Yes	No
High cholesterol	Yes	No
Asthma or other respiratory problem	Yes	No
Arthritis or fibromyalgia	Yes	No

Are you currently taking any medications? \_\_\_\_\_ If so, please list:

Medication_____	Reason_____
Medication_____	Reason_____
Medication_____	Reason_____
Medication_____	Reason_____
Medication_____	Reason_____

Please list any injuries to bones, joints, muscles, with dates of injury and effects on exercise.

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Please list any surgeries that may be currently affecting your ability to exercise:\_\_\_\_\_

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Do you have any back pain or discomfort?\_\_\_\_\_ Please explain.

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**Family health history (parents and siblings)**

Diabetes	Yes	No
Heart disease or heart attack	Yes	No
If yes, at what age_____		
High blood pressure	Yes	No
Stroke	Yes	No