ADMIN USE ONLY:
Referred or brought in by: _____
Inf. Consent signed Y N
Turned in to office: Y N
EZ Facility: Y N
IContact: Y N

HEALTH HISTORY and LIFESTYLE QUESTIONNAIRE

SECTION I (General Information)

Name: _____ Date: _____ Email: _____

Birth Date: (mm/dd/yy) _____Age: _____ COVID vaccination date: _____

Street Address _____ City _____ State: _____ Zip:_____

Cell Phone: _____ Work Phone:_____

Primary Physician: _____ Phone: _____ Referred by: _____

In case of an emergency notify the following person(s):

Name:_____

Address (city & state) :_____

Phone: (C)_____

SECTION II

Describe your primary reason for coming to us. If you primary reason include relief of symptoms, please describe

_____

_____

Do you have any functional limitations in your daily routine, work or recreational activities? If yes, describe:

_____

_____

List your goals for training: 1. _____ 2. _____

_____ 3. _____

If you have physical discomfort, pain or injury, please complete the following section. Circle words that best describe your symptoms:

Sharp	(or)	Ache
Localized	(or)	Radiating
Constant	(or)	Variable
Pain	(or)	Stiffness

Please fill in all that are appropriate:

1. Date of Injury: _____
2. Date Symptoms first appeared: _____
3. Positions/activities that aggravate your symptoms: _____
4. Positions/activities that relieve your symptoms: _____
5. Time of day when symptoms are most apparent: _____

SECTION III (Medical Care)

When was your last physical exam? _____

Check each applicable box for conditions you currently (C) have or have had in the past (P):

C	P		C	P		C	P	
☐	☐	anemia	☐	☐	depression	☐	☐	gout
☐	☐	arthritis	☐	☐	eating disorder	☐	☐	hemophilia
☐	☐	bursitis	☐	☐	epilepsy	☐	☐	HIV
☐	☐	cancer	☐	☐	fibromyalgia	☐	☐	hypoglycemia
☐	☐	cirrhosis	☐	☐	foot problems	☐	☐	lupus/other autoimmune
☐	☐	chronic fatigue	☐	☐	glaucoma			

If you have checked any of the above conditions, please describe below: _____

_____

1. Have any members of your immediate family (mother, father, sister or brother) been diagnosed with cardiovascular disease? ___ Yes ___ No
2. Have you ever been diagnosed with cardiovascular disease? ___ Yes ___ No
3. Do you ever experience an irregular or racing heart rate during exercise or at rest? ___ Yes___ No
4. Do you or have you ever experienced chest pains? ___ Yes ___ No
5. Have you ever had a heart attack, coronary bypass, cardiac surgery, stroke? ___ Yes ___ No
6. Have you ever had an abnormal resting or stress EKG? ___ Yes ___ No
7. Do you have difficulty breathing or unusual shortness of breath? ___ Yes ___ No
8. Have you ever been diagnosed with pulmonary disease or pulmonary problems (Asthma, Emphysema, Bronchitis)? ___ Yes ___ No
9. Have you ever experienced light-headedness or fainting? ___ Yes ___ No
10. Have you ever had or do you have high blood pressure? If yes, what is your blood pressure and is it controlled by medication? Please explain.

    _____

11. Have you been diagnosed with Diabetes? If yes, what type and how is it controlled?

_____

_____

SECTION IV (Medications)

List all medications you are currently taking:

Name	Frequency	Name	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION V (Treatments)

List any hospitalizations, surgeries, physical therapy or chiropractic care:

Date	Age	Condition	Treatment	Outcome/Results
_____				
_____				
_____				

List any other health related practitioners you are currently seeing:

Name	Frequency	Name	Frequency
_____	_____	_____	_____
_____	_____	_____	_____

SECTION VI (Lifestyle)

How do you spend most of your time at work? _____

Do you smoke? _____

How many times per week do you engage in moderate or strenuous exercise for at least 30 minutes?

_____ 1 _____ 2 _____ 3 _____4 _____ 5 _____>5

Describe your energy level?

_____

_____

TRAINING PARTNERS, INC.

Training Policies & Informed Consent

Clients will be charged for all training sessions not cancelled by 5pm the day before their scheduled session. Of course, we know that emergencies and situations arise that are out of your control. These situations will be handled on a case-by- case basis.

Payment for training services can be made per visit or weekly.. All payments should be made to Training Partners, Inc.

By signing this consent, I acknowledge that all information listed above is accurate and that I have voluntarily chosen to participate in a program of progressive physical exercise at Training Partners, Inc. Furthermore, I acknowledge being informed of the strenuous nature of the program and the potential for unusual, but possible, physiological results including but not limited to abnormal blood pressure, fainting, heart attack, or death. I assume all risk for my health and wellbeing and hold harmless of any responsibility, the instructor(s) facility (Training Partners, Inc.), trainer(s), or any person (s) involved with this program and testing procedures.

Client/Member Signature:_____ Date:_____