PTC Fitness

CLIENT HEALTH QUESTIONNAIRE

Please complete and return to PTC Fitness at least 2 days prior to your first class.

All information received on this form will be treated as strictly confidential.

Please fill out the forms completely and accurately.

This information is essential to helping us develop a program that addresses your needs, goals and interests and is safe and effective.

Name: _____ Date of Birth____/____/____ Age:_____

Address: _____
Street City State Zip Code

Phone: _____(h) _____(o) _____(fax)

Email address: _____

Occupation:_____

Emergency Contact: _____ Relationship: _____

Phone Number:_____

Physician's Name: _____ Physician's Phone:_____

Physician's Address: _____
Street City State Zip Code

Because we are a small group we like to know if and when you will be attending classes!
Call or text at 803-394-8950.
Email: PTCpoole@aol.com
Or Message Melissa Davis on Facebook!

PTC Fitness

Mailing Address: P.O. Box 1221 Swansea, SC 29160

Phone. 803-568-3158 Fax. 803-568-2751

http://pooletrainingcenter.com/Exercise%20Classes.htm

Please Circle YES or No to the following:

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?

Yes or No

Do you frequently have pains in your chest when you perform physical activity?

Yes or No

Have you had chest pain when you were not doing physical activity?

Yes or No

Do you lose your balance due to dizziness or do you ever lose consciousness?

Yes or No

Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?

Yes or No

Are you pregnant now or have given birth within the last 6 months?

Yes or No

Have you had a recent surgery?

Yes or No

Do you take any medications, either prescription or non-prescription, on a regular basis?

Yes or No

Please circle the correct answer to each of the following conditions you have had or now have and list any medication you are currently taking for that condition. Also check medical conditions in your family (father, mother, brother(s), or sister(s)). Check all that apply.

Personal Family Medical Condition Medication

Coronary heart disease, heart attack

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Angina

FAMILY MEMBER or YOURSELF or N/A

Medications _____

High blood pressure ___ mm Hg

FAMILY MEMBER or YOURSELF or N/A

Medications _____

High cholesterol _____ mg/dl

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Peripheral vascular disease

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Phlebitis or emboli

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Epilepsy

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Stroke

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Emphysema

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Pneumonia

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Asthma

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Bronchitis

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Diabetes (specify type: _____)

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Thyroid conditions

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Osteoporosis

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Arthritis

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Anemia (low iron)

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Bone fracture

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Depression

FAMILY MEMBER or YOURSELF or N/A

Medications _____

High anxiety, phobias

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Eating disorders (anorexia,bulimia)

FAMILY MEMBER or YOURSELF or N/A

Medications _____

Sleeping problems

FAMILY MEMBER or YOURSELF or N/A

Medications _____

How do the medications you are on affect your ability to exercise or achieve your fitness goals?

_____

If you have marked YES to any of the above, please elaborate below:

_____

Lifestyle Related Questions:

1) Do you smoke? YES NO If yes, how many?_____

2) Do you drink alcohol?Y ES NO If yes, how many glasses per week?_____

3) How many hours do you regularly sleep at night? _____

4) Describe your job: __ Sedentary __ Active __ Physically Demanding

5) Does your job require travel? YES NO

6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____

7) List your 3 biggest sources of stress:

a. _____ b. _____ c._____

8) Is anyone in your family overweight? __Mother __Father __Sibling __Grandparent

9) Were you overweight as a child? YES NO If yes, at what age(s)?_____

Fitness History:

1) When were you in the best shape of your life? _____

2) Have you been exercising consistently for the past 3 months? YES NO

3) When did you first start thinking about getting in shape? _____

4) What if anything stopped you in the past? _____

5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)?_____

Nutrition Related Questions

1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? _____

2) How many times a day do you usually eat (including snacks)? _____

3) Do you skip meals? YES NO 4) Do you eat breakfast? YES NO

5) Do you eat late at night? __ Sometimes __Often __ Never

6) What activities do you engage in while eating? (TV, reading etc) _____

7) How many glasses of water do you consume daily? _____

8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when?_____

9) Do you know how many calories you eat per day? YES NO If yes, how many?_____

10) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N

If yes, please list the supplements:

_____

11) At work or school, do you usually: __Eat out __Bring food

12) How many times per week do you eat out? _____

13) Do you do your own grocery shopping? YES NO

14) Do you do your own cooking? YES NO

15) Besides hunger, what other reason(s) do you eat?

__Boredom __Social __Stressed __Tired __Depressed __Happy __Nervous

16) Do you eat past the point of fullness? __Often __Sometimes __Never

17) Do you eat foods high in fat and sugar? __Often __Sometimes __Never

18) List 3 areas of your Nutrition you would like to improve:

a._____ b._____ c._____

Exercise Related Questions: Skip to next section if you are presently inactive.

1) How often do you take part in physical exercise?

5-7x/week 3-4x/week 1-2x/week

2) If your participation is lower than you would like it to be, what are the reasons?

Lack of Interest Illness/Injury Lack of Time Other_____

3) How long have you been consistently physically active for? _____

4) What activities are you presently involved in?

Cardio &/or Sports Frequency/Week Average Length Easy/Mod/Hard

_____ _____

_____ _____

_____ _____

Strength Training Frequency/Week Average Length Easy/Mod/Hard

_____

List exercises:_____

_____

Stretching Frequency/Week Average Length

_____

Developing your Fitness Program:

1. Please circle how you prefer to exercise:

a) INSIDE OUTSIDE COMBINATION

b) LARGE GROUPS SMALL GROUPS ALONE COMBINATION

c) MORNING AFTERNOON EVENING

2. Realistically, how often a week would you like to exercise? _____x/week

3. Realistically, how much time would you like to spend during each exercise session? _____

4. What are the best days during the week for you to commit to your exercise program?

M T W T F S S

5. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY SUNDAY

Goal Setting:

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

S= Specific (Provide details, how long, how much etc.)

M= Measurable (How will you measure whether you've reached your goals)

A= Attainable (Be realistic, set smaller goals)

R = Rewards-Based (Attach a reward to each goal)

T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

a)_____

b)_____

c)_____

2. Where do you rate health in your life? __ Low priority __Medium Priority __High priority6

3. How committed are you to achieving your fitness goals? __ Very __Semi __Not very