CNEP
Health and Medical History Questionnaire

Personal Information

Name: _____ M or F Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Date of Birth: _____ Age: _____ Height: _____ Weight:_____

Occupation:_____ Place of Employment: _____

Education (Highest Degree Obtained): _____

Email Address: _____ (used for emailing test results)

If Minor- Parents name:_____

Person to contact in case of emergency: _____ Relation: _____

Personal Physician: _____ Phone ( ) _____

Physician Address (email): _____

List any chronic illness for which you sought medical care:

_____ Date :_____

_____ Date :_____

_____ Date :_____

_____ Date :_____

How did you hear about us? _____

Admit Forms

Medical History:

It is very important that you give us accurate and complete information about your medical history. Training programs and procedures recommended will be based on information given.

1. Do you have any current health conditions that would limit your participation in a fitness program? Yes No
If yes, please explain: _____
_____
_____

2. Have you ever been advised by a physician to avoid any type of exercise? Yes No
If yes, please explain: _____
_____
_____

3. Are you currently taking any medications, OTC or supplements? Yes No
If yes, please explain: _____
_____
_____

4. Please explain any surgeries or hospitalizations you have had (please lists dates):
_____
_____
_____

5. Please list chronic illness for which you sought medical care:
_____
_____
_____

6. Have you been told by a physician that you have any of the following:

Condition	Yes	No	Date	Medications
Anemia	Yes	No	_____	_____
Arthritis	Yes	No	_____	_____
Asthma	Yes	No	_____	_____
Bursitis	Yes	No	_____	_____
Chest Pain	Yes	No	_____	_____
Coronary Artery Disease	Yes	No	_____	_____
Diabetes	Yes	No	_____	_____
Emotional Disorders	Yes	No	_____	_____
Emphysema	Yes	No	_____	_____
Epilepsy	Yes	No	_____	_____
Heart Attack	Yes	No	_____	_____
Heart Murmur	Yes	No	_____	_____
Hepatitis	Yes	No	_____	_____
High Cholesterol	Yes	No	_____	_____
High Blood Pressure	Yes	No	_____	_____
Irregular Heart Beat	Yes	No	_____	_____
Low Blood Pressure	Yes	No	_____	_____
Pneumonia	Yes	No	_____	_____
Stroke	Yes	No	_____	_____
Tuberculosis	Yes	No	_____	_____
Other: _____	Yes	No	_____	_____

7. Do you have any allergies? Yes No If yes, please list: _____
_____

8. Are you allergic to any medications? Yes No If yes, please list: _____
_____

9. Do you smoke? Yes No If yes, how much and for how long: _____

10. Do you drink alcoholic beverages? Yes No If yes, how much per week: _____

11. How many Caffeine drinks per day ? _____

Exercise Medical History:

1. Have you ever had chest pains or irregular heart beat when exercising: Yes No
If yes, please explain: _____
_____

2. Have you experienced dizziness or felt light headed when exercising? Yes No
If yes, please explain: _____
_____

3. Have you ever had shortness of breath, or have you ever hyperventilated during exercise? Yes No
If yes, please explain: _____
_____

4. Are you presently, or did you seek out the help of a physician for any of the above conditions? Yes No
If yes, please explain: _____
_____

5. Do you have any type of biomechanical joint problems? Yes No
If Yes explain: _____

6. Do you currently have any exercise-induced injuries? Yes No
If Yes explain: _____

7. Have you had a previous exercise-induced injury? Yes No
If Yes explain: _____

8. Were medical care and/or physical therapy involved? Yes No

9. Are you currently involved in any type of exercise routine? Yes No
If No, how long has it been since you last participated in a consistent exercise routine? -
_____

10. What type of exercise was it? _____

11. If Yes, how many times a week do you currently exercise? _____

12. Please list your activities and the frequency, duration and intensity of each:

Activity	Frequency	Duration	Intensity
Example: running	4x per week	30 minutes	moderate

Comments:
_____
_____
_____
_____

Orthopedic Evaluation:

1. Do you have any type of orthopedic condition which may hamper your Exercise/Fitness training (i.e. tendinitis, bursitis, therapy, surgery, etc.)? Yes No
If Yes, please explain: _____
_____

2. Are you under a physicians or therapists care for an orthopedic condition? Yes No
If yes, please explain: _____
_____

Nutrition Assessment / Weight History: *(3-day food record is attached as a separate file)*

1. When you graduated from HS what was your Height and Weight. _____

2. In the last 2 to 3 years have you gained or lost weight? Yes No
If Yes, please explain:_____
_____
_____

3. Peri/Post Menopause: _____

4. What weight do you feel good at? _____

5. Do you have any food allergies? Yes No
If Yes, please explain: _____
_____
_____

6. Do you have and Dietary Limitations? Yes No
If Yes, please explain: _____
_____
_____

7. Are you able to prepare you own meals? Yes No Describe: _____
_____ _____

8. How many times a week do you eat out or order restaurant food and eat in? _____

9. How many times a week do you or your family prepare meals? _____

10. Have you followed any diet or meal plan for an extended time to lose weight? Yes No Describe
_____
_____
_____

Family History:

**Has any member of your family been diagnosed with or died from any of the following health conditions:

	Condition	Age at diagnosis or death:
1.	Congestive Heart Failure	_____
2.	Diabetes	_____
3.	Heart Attack	_____
4.	High Blood Pressure	_____
5.	Stroke	_____

3-Day Food Log

- Report three (3) days of your normal or daily eating habits/patterns
- Please be very specific about portions, using measurements of cups, and plate size
- (Ex. 2 cups of cheerios with 1 cup of 2% milk)

Day 1

Breakfast

_____
_____
_____
_____

Lunch

_____
_____
_____
_____

Dinner

_____
_____
_____
_____

Snacks

_____
_____
_____
_____

Day 2

Breakfast

_____
_____
_____
_____

Lunch

_____
_____
_____
_____

Dinner

_____
_____
_____
_____

Snacks

_____
_____
_____
_____

Day 3

Breakfast

_____
_____
_____
_____

Lunch

_____
_____
_____
_____

Dinner

_____
_____
_____
_____

Snacks

_____
_____
_____
_____

Exercise Questionnaire

1. What are the main goals related to starting an exercise program?(select all that apply)

❑ Physical Fitness
❑ Achieve a particular goal (i.e., start a new activity, participate in an event (specify)

_____

❑ Lose Weight
❑ Other: (please specify)

_____

2. Do you anticipate any barriers to starting an exercise program? (select all that apply)

❑ Lack of time
❑ Lack of enjoyment from exercise
❑ Lack of self-discipline
❑ Lack of equipment
❑ Fatigue or feeling unwell
❑ Weather
❑ Financial
❑ Other responsibilities: (e.g., family, job, volunteer position)
❑ Other (specify)

_____

3. What type of programming best fits your needs? (although more than one option may exist, please select one that would be completed 3-4x weekly)

❑ Home workout (body weight/Theraband)
❑ Home workout (weights and/or machine)
❑ Gym workout (variety of equipment)
❑ Yoga
❑ Circuit Training/HIIT Training
❑ Yoga/Pilates
❑ Other: (specify)

_____

4. Do you have any specific concerns about exercise? Be as detailed as possible.

_____
_____
_____
_____
_____
_____
_____