Indicate if condition pertains to you. Indicate if condition runs in your family.

- ☐ ALCOHOLISM ☐
- ☐ ALLERGIES ☐
- ☐ ANEMIA ☐
- ☐ ARTHRITIS ☐
- ☐ CANCER Your Condition_____ ☐
  Date Diagnosed _____
  Treatment _____

- ☐ CARDIOVASCULAR DISEASE ☐ Arrhythmia ☐ Bypass Surgery ☐ Chest Pains ☐
  ☐ Heart Attack ☐ Valve Replacement ☐ Other _____
- ☐ HIGH CHOLESTEROL Total _____ HDL _____ LDL _____ ☐
- ☐ HIGH TRIGLYCERIDES Total _____ ☐ Homocysteine Total _____ ☐
- ☐ BLOOD PRESSURE ☐ High _____ / _____ ☐ Low _____ / _____ ☐
- ☐ STROKE Date _____ ☐

- ☐ CHRONIC FATIGUE SYNDROME ☐
- ☐ CHRONIC INSOMNIA ☐
- ☐ CHRONIC PAIN Body Part _____ Duration _____ ☐
- ☐ CONCUSSION ☐
- ☐ DIABETES ☐ Insulin Dependent ☐ Oral Medication ☐
  ☐ Non-Insulin Dependent ☐
- ☐ DIZZINESS/FAINTING ☐
- ☐ EATING DISORDER ☐ Anorexia ☐ Bulimia ☐
- ☐ EPILEPSY ☐
- ☐ FIBROMYALGIA ☐
- ☐ GALLBLADDER DISEASE ☐
- ☐ HEADACHES ☐
- ☐ HIATAL HERNIA/REFLUX ☐
- ☐ HYPOGLYCEMIA ☐
- ☐ INFECTIOUS/VIRAL DISEASE ☐
- ☐ INTESTINAL PROBLEMS ☐ Colitis ☐ Constipation ☐ Crohn's ☐
  ☐ Diarrhea ☐ Diverticulitis/osis ☐ Lactose Intolerant
  ☐ Parasites ☐ Irritable Bowel ☐ Other _____
- ☐ KIDNEY DISEASE ☐
- ☐ LIVER DISEASE ☐
- ☐ LUNG DISEASE ☐ Asthma ☐ Emphysema ☐ Other _____ ☐
- ☐ LYME DISEASE
- ☐ MENSTRUAL HISTORY ☐ Cramps ☐ Irregular Periods ☐ Menopausal ☐
  ☐ Children _____ ☐ Pregnancies _____ ☐ Other _____

Indicate if condition pertains to you. Indicate if condition runs in your family.

☐ ORTHOPEDIC PROBLEMS	☐ Ankle	☐ Arthritis	☐ Back	☐
	☐ Foot	☐ Hip	☐ Knee	
	☐ Shoulder	☐ Tendonitis	☐ Other _____	
☐ OSTEOPOROSIS				☐
☐ TUBERCULOSIS				
☐ THYROID DISEASE	☐ Hyperthyroidism	☐ Hypothyroidism		☐
☐ ULCERS				☐

RELATED MEDICAL HISTORY

Personal Surgical History _____

Present Medications _____

Physician's Name _____ Phone _____

Date of Last Physical Exam (Month/Year) _____ Reason _____

Do you have any conditions that can be exacerbated by exercise?

_____

_____

LIFE / LIFESTYLE HISTORY

Marital Status _____ Occupation _____

☐ Do you drink alcoholic beverages? _____ How much / How often? _____

☐ Do you / Did you smoke? How much / How often? _____

☐ Do you use recreational drugs? How much / How often? _____

Your daily stress level? ☐ High ☐ Medium ☐ Low

Describe any stress-reduction techniques that you utilize. _____

Have you ever or do you presently see a Psychiatrist / Physiologist? _____

1. Rate your level of participation in fitness on a scale of 1 to 5 (less to more) for each age range to date.
   15-20 _____ 21-30 _____ 31-40 _____ 41-50 _____ 50+ _____

2. Were you a high school and/or college athlete?
   Sport (s) _____ Level _____

3. Have you any bad experiences with physical activity programs or harbor any negative feelings towards exercise?
   Yes _____ No _____
   If yes, please explain: _____

_____

_____

4. Do you start exercise programs but then find yourself unable to stick with them?
   Yes _____ No _____

5. How much time are you will to devote to an exercise program?
   Minutes/Day _____ Days/Week _____

6. Can you exercise during your work day?
Yes _____ No _____

7. Would an exercise program interfere with your job or other responsibilities?
Yes _____ No _____

Rate yourself on a scale of 1 to 5 (less to more). Circle the number that applies most.

1. Characterize your present athletic ability.
1 2 3 4 5

2. When you exercise, how important is competition?
1 2 3 4 5

3. Characterize your present cardiovascular capacity.
1 2 3 4 5

4. Characterize your present muscular/strength capacity.
1 2 3 4 5

5. Characterize your present flexibility capacity.
1 2 3 4 5

Describe your current exercise routine(s). _____

Rate your perception of the intensity of your exercise routines (Circle)
1. Light 2. Fairly Light 3. Somewhat Hard 4. Hard

What are your hobbies and interest?

NUTRITIONAL HISTORY

Please list your food and beverage intake for the last 24 hrs.

Cups of coffee per day _____ Caf. / De-Caf. Cups of tea per day _____ Caf. / De-Caf.

Cans of soda/iced tea/juice per day _____ Caf. / De-Caf.

Vitamin, Mineral and Supplement Intake

Dining out per week ☐ None ☐ 1 to 3 ☐ 4 or more

List most frequented restaurants

Height (ft,in) Highest weight or bodyfat percentage: _____

Lowest weight or bodyfat percentage: _____

Desired weight or bodyfat percentage _____

Desired shape / body type _____

Are there any issues regarding your nutrition history that you feel we should know?