Louise Cottingham
S/NVQ LEVEL 2 RSA/OCR
Group & One to One Fitness Instructor
Natural Juice Therapist Practitioner (Cma) Level 3
Nutrition & Weight Management Advisor

HEALTH HISTORY QUESTIONNAIRE

NAME: **DATE OF BIRTH:**

MOBILE/WORK TEL: **HOME TEL:**

WEIGHT: **HEIGHT:**

EMERGENCY CONTACT NAME & NUMBER:

RELATIONSHIP:

ADDRESS

E-MAIL:

**IN ORDER TO DESIGN A SAFE AND EFFECTIVE FITNESS PROGRAMME,
IT IS IMPORTANT THAT YOU COMPLETE THE FOLLOWING HEALTH HISTORY.
ALL INFORMATION IS KEPT STRICTLY PRIVATE AND CONFIDENTIAL.**

READ ALL QUESTIONS THOROUGHLY. Answer YES or NO

Has your doctor ever told you that you have heart problems:

Has your doctor ever told you that you have high blood pressure:

Have you ever had a stroke or heart attack:

Have you ever had pain in your chest:

Do you ever feel faint or have dizzy spells:

Have you had surgery in the last six months:

DO YOU SUFFER FROM ANY OF THE FOLLOWING? Answer YES or No

Diabetes:	Blood pressure:	Asthma :	Arthritis:
Epilepsy:	High cholesterol:	Heart Problems:	Pregnancy:

HAVE YOU INJURED OR HAVE PAIN IN THE FOLLOWING AREAS? Answer YES or No

Neck:	Hips:	Shoulders:	Elbows:
Lower back:	Upper back:	Wrists:	Knees:

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If you answered 'YES' to any of the above, please explain:

IF YOU ARE CURRENTLY TAKING ANY MEDICATION, PLEASE LIST BELOW:

Medication:	Condition:	Dosage:
Medication:	Condition:	Dosage:

ARE YOU CURRENTLY UNDERGOING TREATMENT FROM ANY OF THE FOLLOWING? Answer YES or No

Physiotherapist:	Chiropractor:	Massage therapist:

If 'YES' please explain why:

HOW MANY TIMES DO YOU EXCERSIZE PER WEEK? Answer YES or No

None:	2 to 3 times:	More than 4:

HOW WOULD YOU RATE YOUR LEVEL OF STRESS ON A DAILY BASIS? Answer YES or No

Low:	Moderate:	High:

WHAT DO YOU THINK YOUR IDEAL WEIGHT SHOULD BE?
Answer:

HAVE YOU EVER BEEN YOUR IDEAL WEIGHT? Answer YES or No:

IF 'YES' HOW LONG AGO?

One year:	Three years:	More than five years:

ARE YOU CURRENTLY FOLLOWING ANY TYPE OF SPECIAL DIET?

Low fat:	Reduced calorie:	Increased calorie:
Low salt:	Low cholesterol:	Other:

WHAT ARE YOUR EXERCISE GOALS?
Number the following exercise benefits according to their importance to you with '1' being the most important.

Weight loss: 0	Weight gain: 0	Stress reduction: 0
Increase strength:	Posture: 0	Cardiovascular conditioning:
Other:		

ESTIMATE HOW MANY HOURS OF SLEEP YOU GET EACH NIGHT:

ARE THERE ANY OTHER REASONS (HEALTH OR PERSONAL) THAT MAY LIMIT OR PREVENT YOU FROM EXERCISING? Answer YES or No: