**Client Data Questionnaire**

Please answer each of these questions as accurately as you can. Should you have any questions, feel free to ask. Your responses will be treated in a confidential manner.

|  |  |
| --- | --- |
| Today's Date:Date of Birth:Address:City:Zip:Email Address:Home Phone:Emergency Contact:Relationship: Doctor: |  / / Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   / /­­­­\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_  |
|  |  |

 **Medical/Health Status Questionnaire**

On this questionnaire, a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. Please place a check in the space to the left of the question to answer "Yes." Leave blank if your answer is "No." Please ask if you have any questions. Your responses will be treated in a confidential manner.

**Medical Screening**

**□** Do you have any personal history of heart disease (coronary or atherosclerotic disease)?

**□** Any personal history of diabetes or other metabolic disease (thyroid,renal,liver)?

**□** Any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?

**□** Have you experienced pain or discomfort in your chest apparently due to blood flow deficiency?

**□** Any unaccustomed shortness of breath (perhaps during light exercise)?

**□** Have you had any problems with dizziness or fainting?

**□** Do you have difficulty breathing while standing or sudden breathing problems at night?

**□** Have you experienced a rapid throbbing or fluttering of the heart?

**□** Do you suffer from ankle edema (swelling of the ankles)?

**□** Have you experienced severe pain in leg muscles during walking?

**□** Do you have a known heart murmur?

**□** Has your serum cholesterol been measured at greater than 200 mg/dl?

**□** Are you a cigarette smoker?

**□** Has your HDL (the "good" cholesterol) been measured at greater than 60 mg/dl?

**□** Would you characterise your lifestyle as "sedentary"?

**□** Have you had a high fasting blood glucose level on 2 or more occasions (>=110mg/dl)?

**□** Are you 20% or more overweight or have you been told your “BMI” was greater than 30?

**□** Have you been assessed as hypertensive on at least 2 occasions (systolic > 140 mmHg or diastolic > 90mmHg)?

**□** Do you have any family history of cardiac or pulmonary disease prior to age 55?

**□** Are you sitting at a desk for more than 2 hours per day?

**Medical History - Detail**

**□** Are you currently being treated for high blood pressure?

 If you know your average blood pressure, please enter: \_\_\_\_\_/\_\_\_\_\_\_

Please check all conditions or diagnoses that apply:

|  |  |  |
| --- | --- | --- |
| **□** Abnormal EKG? | **□** Limited Range of Motion? | **□** Stroke? |
| **□** Abnormal Chest X-Ray? | **□** Arthritis? | **□** Do You Suffer from Epilepsy or Seizures? |
| **□** Rheumatic Fever? | **□** Bursitis? | **□** Chronic Headaches or Migraines? |
| **□** Low Blood Pressure? | **□** Swollen or Painful Joints? | **□** Persistent Fatigue? |
| **□** Asthma? | **□** Foot Problems? | **□** Stomach Problems? |
| **□** Bronchitis? | **□** Knee Problems? | **□** Hernia? |
| **□** Emphysema? | **□** Back Problems? | **□** Anemia? |
| **□** Other Lung Problems? | **□** Shoulder Problems? | **□** Are You Pregnant? |
| **□** Joint Implants?  (i.e. hip, knee) | **□** Recently Broken Bones? | **□** Other Major Surgeries? If so, please specify below. |

**□** Has a doctor imposed any activity restrictions? If so, please describe:

**Family History**

Have your mother, father, or siblings suffered from (please select all that apply):

|  |  |
| --- | --- |
| **□** Heart attack or surgery prior to age 55. | **□** High cholesterol |
| **□** Stroke prior to age 50. | **□** Diabetes |
| **□** Congenital heart disease or left ventricular hypertrophy. | **□** Obesity |
| **□** Hypertension | **□** Asthma |
| **□** Leukemia or cancer prior to age 60. | **□** Osteoporosis |

**Medications**

Please Select Any Medications You Are Currently Using:

|  |  |
| --- | --- |
| **□** Diuretics | **□** Other Cardiovascular |
| **□** Beta Blockers | **□** NSAIDS/Anti-inflammatories (Motrin, Advil) |
| **□** Vasodilators | **□** Cholesterol |
| **□** Alpha Blockers | **□** Diabetes/Insulin |
| **□** Calcium Channel Blockers | **□** Other Drugs (record below). |

Please list the specific medications that you currently take:

**Please Rate Your Daily Stress Levels (select one):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **□** Low | **□** Moderate | **□** High but I enjoy the challenge | **□** High: sometimes difficult to handle | **□** High: often difficult to handle. |

**Other**

Please Indicate Any Other Medical Conditions or Activity Restrictions That You May Have. It is important that this information be as accurate and complete as possible

**□** Is any of this information critical to understanding your readiness for exercise? Are there any other restrictions on activity that we should know about?

**Exercise Habits & Interests Questionnaire**

**Recent Exercise Habits:**

How many times per week are you active enough to break a sweat? \_\_\_\_\_

When you exercise, how long are you active? \_\_\_\_\_\_ minutes

On a scale from 1 to 10, how intense is your typical activity? \_\_\_\_\_

How many years have you exercised? \_\_\_\_\_

**In a Typical Week, How Many Minutes Do You Spend in the Following Activities:**

|  |  |  |  |
| --- | --- | --- | --- |
| Running/Jogging Walking |  | Stair Climber |  |
| Aerobics Racquet Sports |  | Yoga/Pilates |  |
| Swimming Weight Training |  | Skiing |  |
| Biking |  | Other |  |

**Thank you for taking the time to complete this questionnaire**

**AGREEMENT AND RELEASE OF LIABILITY
FOR PERSONAL TRAINING**

1. In consideration of being allowed to participate in personal training with Jenny Connaway, and to use facilities, equipment, and machinery as needed, I do hereby waive, release and forever discharge Jenny Connaway from any and all responsibilities or liability for injuries or damage resulting from my participation in any activities or my use of participation in any activities with Jenny Connaway. I do also hereby release Jenny Connaway and any other acting upon it’s behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on her behalf or in any way arising out of or connected with my participation in any activities or use of any equipment of Jenny Connaway.

 **(Please initial )**

1. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are potentially hazardous activities. I also understand that fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risk of injury or death.

**(Please initial )**

1. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in any of the activities and programs with Jenny Connaway or use of equipment or machinery except as here in after stated. I do hereby acknowledge that I have been informed of the need for a physician’s approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given any physician’s permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

**(Please initial )**

**Print name Date**

**Signature**