



HEALTH HISTORY EVALUATION FORM

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Cell #: _____ Home #: _____ Work #: _____
 Email: _____
 Emergency contact: _____ Phone: _____
 Physician's Name: _____ Phone: _____
 How did you learn about Stone Bodyworks? _____

HEALTH HISTORY

1. Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> History of heart problems, chest pain or stroke | <input type="checkbox"/> Cigarette smoking habit: <i>Amount/ day?</i> _____ |
| <input type="checkbox"/> Family history of heart disease, stroke, or cancer | <input type="checkbox"/> Increased blood cholesterol |
| <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Diabetes or thyroid condition |
| <input type="checkbox"/> Chronic illness or condition | <input type="checkbox"/> Advice from a physician not to exercise |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Pregnancy, Hysterectomy, Pre- menopause,
Post Menopause |
| <input type="checkbox"/> Difficulty with exercise | <input type="checkbox"/> History of breathing or lung problems |
| <input type="checkbox"/> Muscle, joint, back disorder, or previous injury | <input type="checkbox"/> Car accident |
| <input type="checkbox"/> Hernia, or any other condition that may be
aggravated by lifting weights | <input type="checkbox"/> Diagnosed with any other condition by a physician or
practitioner |

2. Please describe in full detail any items that you have marked:

3. Are you taking any medications, vitamins, or dietary supplements at this time? Yes No

If yes, please list: _____



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Please list the medical & non-medical care providers you are currently under:

4. Date of last physical exam: _____

OCCUPATIONAL INFORMATION

1. What is your current occupation and how long have you been doing this? _____

2. Does your occupation require extended periods of sitting? Yes No

3. Does your occupation require extended periods of repetitive movements? Yes No

If yes, please explain: _____

4. Does your occupation cause you anxiety/ mental stress? Yes No

If yes, how would you rate this stress on a scale of 1-5? (5 being extremely stressful) _____

PHYSICAL ACTIVITY

1. Do you partake in any recreational activities and/or sports? Yes No

If yes, please explain: _____

2. Do you have any hobbies (reading, gardening, etc.)? Yes No

If yes, please explain: _____

3. Are you currently involved in a regular fitness program? Yes No

If yes, what type and how often? _____

4. Do you consider yourself:

Sedentary Lightly active (sporadic workouts, lawn work, little aerobic activity)

Moderately active (work out 1-2 days/ week for at least 15-30 min.)

Highly active (workout 3 or more days/ week for at least 30-45 min.)

5. How physically fit do you feel at the present time?

Unfit Average Very fit

Less than average Above average Don't know

6. Indicate the main reason why you exercise or why you would like to begin an exercise program:

It is good for my health It helps to relieve stress

For weight loss My doctor told me to

It makes me feel good Other: _____



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7. What activities would/ do you prefer in a regular exercise program?

- | | | |
|--|--|---|
| <input type="checkbox"/> Walking/ hiking | <input type="checkbox"/> Cycling | <input type="checkbox"/> Stretching/ Yoga |
| <input type="checkbox"/> Running | <input type="checkbox"/> Strength Training | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Racquetball/ Squash | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Rowing | <input type="checkbox"/> Group fitness classes | <input type="checkbox"/> Not sure |
| <input type="checkbox"/> Other: _____ | | |

8. What time of day would you prefer to workout?

- | | | |
|--|---|---|
| <input type="checkbox"/> Early morning (5 - 7am) | <input type="checkbox"/> Afternoon (1- 4pm) | <input type="checkbox"/> Late evening (8- 10pm) |
| <input type="checkbox"/> Mid morning (8am -12) | <input type="checkbox"/> Early evening (5- 7pm) | |

NUTRITION & WELLNESS

9. How much water do you drink on a daily basis?

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> 0-3 glasses | <input type="checkbox"/> 6-8 glasses |
| <input type="checkbox"/> 2-6 glasses | <input type="checkbox"/> 8 + glasses |

10. How would you describe your eating habits? Please mark all that apply.

- | | | |
|---|---|--|
| <input type="checkbox"/> I skip breakfast | <input type="checkbox"/> I eat 4-5 meals throughout the day | <input type="checkbox"/> I eat 3-5 fresh fruit/ vegetables |
| <input type="checkbox"/> I eat 1-2 meals/ day | <input type="checkbox"/> I often snack after dinner/ before bed | <input type="checkbox"/> I eat 5 + fruit/ vegetables |
| <input type="checkbox"/> I eat 3-meals/ day | <input type="checkbox"/> I rarely eat fresh fruits/ vegetables | <input type="checkbox"/> I eat protein with every meal |
| <input type="checkbox"/> Other: _____ | | |

11. Are you currently following a specific diet? Yes No

If yes, please explain: _____

12. Check any that apply to you:

- | | | | |
|-----------------------------------|---------------------------|----------------------------------|---------------------------|
| <input type="checkbox"/> Caffeine | Amount & frequency: _____ | <input type="checkbox"/> Alcohol | Amount & frequency: _____ |
|-----------------------------------|---------------------------|----------------------------------|---------------------------|

GOALS

1. Long-term goals: Where do you want to be in 6 months to a year?

- a. _____
- b. _____
- c. _____

2. Short-term goals: What small goals can you set to assist you in accomplishing your long-term goals?

- a. _____



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- b. _____
- c. _____

3. Is there anything that you feel could get in the way of you achieving your goals?

By signing below, I acknowledge that I have carefully read the health history evaluation form and answered the questions truthfully. It is advised that if I answered YES to any of the questions on the health history evaluation, that I should consult a physician prior to starting an exercise plan. In addition, I understand the above questions and will act on my own accord in taking full responsibility for my actions in choosing to continue with a qualified health and fitness professional without consulting my physician.

Signature

Date