



# Health History Intake Form

When you complete this form, please send to:

**Fitness Essentials, LLC**  
317 S. Dallas Ave.  
Pittsburgh, PA 15208

## Health/Fitness History

(Confidential Information)

### General Information

Referred By  Date

Name  (Last)  (First)  (MI)

PAA Member Number  Fitness Number

Address  City  ST  Zip

Email

Home Phone  Work Phone

Occupation

Age  Date of Birth  /  /  Sex  Height  Weight

Drug Allergies

### Physician Information

Physician's Name  Type of Physician

Business Address  City  ST  Zip

Phone

Has your physician referred you to an exercise program?  Yes  No

Have you ever had a Stress Test?  Yes  No If yes, how long ago?

For what reason was this test performed?

Has your physician cleared you to exercise?  Yes  No  No physician comment

Would you like progress reports sent to your physician?  Yes  No

## Personal Health History

(Please check the appropriate column, if applicable)

	Personal	Family		Personal	Family
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hypotension	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	(Specify)	<input type="text"/>	
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
(Specify type/location)	<input type="text"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Claudication	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Condition	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Severe Headache	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify)	<input type="text"/>	

## Medications

Are you currently taking any medications?  Yes  No

If yes, please list medication:

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

## Orthopedic and Other Health Concerns

Have you ever had muscle, bone or joint illness or injury (including the back) in the past?  Yes  No

If yes, please explain:

<input type="text"/>
<input type="text"/>
<input type="text"/>

Do you currently have any muscle, bone or joint problems that may affect your activity level?  Yes  No

Please explain any other health concerns or complications

<input type="text"/>
<input type="text"/>

Has a physician ever placed any restrictions on your activities?  Yes  No

If yes, please explain:

<input type="text"/>
<input type="text"/>

## General Health Status

Do you have a history of high cholesterol?  Yes  No      Do you know your value?  Yes  No

Has your body weight changed more than 10 pounds in the last year?  Yes  No

How would you evaluate your health status over the past 6 months?

Same                       Better                       Somewhat Worse                       Significantly Worse

Do you presently feel that you are in good health?  Yes  No

How many hours of sleep do you get a night?

Other comments:

## Personal Habits

Do you smoke at present?  Yes  No      Have you ever smoked?  Yes  No

If yes, when did you quit?

Years smoked?

If currently smoking, would you like to quit?  Yes  No

## Nutrition *(For nutritional consultation, please fill out the Diet/Nutrition History attached to the end of this form)*

## Exercise

Do you currently engage in any form of regular exercise?  Yes  No      If yes, please specify:

Have you ever participated in a regular exercise program?  Yes  No      If yes, please specify:

Have you ever participated in competitive athletics?  Yes  No      If yes, please specify:

How much physical exertion is required in your occupation? Please specify:

What is your primary reason for starting an exercise program?

Please list at least three goals you wish to achieve through your personal fitness program, in order of importance:

What types of activities do you enjoy?

Are there any activities that you would like to try that you have never done before?

Are there any activities in which you do not want to participate?

Are there any other comments or concerns we need to know prior to your starting a personal fitness program?



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### Diet/Nutrition History

(Confidential Information)

#### Nutrition

What do you consider a good weight for yourself?

What is the most you have ever weighed?

Number of meals you eat per day?

Number of meals you eat at home per day?

How many times a day do you eat (including snacks)?

Do you do the cooking at home?  Yes  No

Do you drink alcoholic beverages?  Yes  No

Do you use salt?  Yes  No

Do you drink coffee, tea or colas?  Yes  No Cups/glasses per day?

Do you take vitamins?  Yes  No If yes, please list:

Do you take any supplements?  Yes  No If yes, please list:

Are you on a special diet now?  Yes  No If yes, please explain:

Approximately how many 8 oz. glasses of water do you drink per day?

Would you consider the portion size of your meals to be:  small  medium  large

What kind of snacks do you choose?

Approximately how many servings of fruit do you eat per day?

Approximately how many servings of vegetables do you eat per day?

Do you read food labels?  Yes  No

Do you consider your meals to be balanced?  Yes  No

How many meals a day do you eat sitting down at a table?

How many meals a day do you eat on the run?

Do you watch TV, read or listen to music when you eat?

Do you use artificial sweeteners?  Yes  No

Do you eat breakfast?  Yes  No