Personal Training Program
Health History Questionnaire

NAME:____ TODAY'S DATE:________________

ADDRESS:____DATE OF BIRTH:_____________________

CITY:____________________________________STATE:____________ZIP CODE:_______________________

HOME PHONE:________________________________CELL PHONE:_________________________________

EMAIL ADDRESS:____

EMERGENCY CONTACT INFORMATION

NAME:____

RELATIONSHIP:____

PHONE #:____

PHYSICAL ACTIVITY

CURRENT LEVEL OF PHYSICAL ACTIVITY PER WEEK: (CIRCLE ONE)

0-60 minutes 1-3 hours 4-7 hours Other:___________

HOW LONG HAVE YOU BEEN EXERCISING REGULARLY? (CIRCLE ONE)

Not Currently Active 1-6 months 7-12 months 12+ months

WHAT IS YOUR DESIRED LEVEL OF PHYSICAL ACTIVITY PER WEEK? (CIRCLE ONE)

0-60 minutes 1-3 hours 4-7 hours Other:___________

DENVER
PARKS & RECREATION

Please circle any symptoms you are currently experiencing or mark the circle if you are not experiencing any of these symptoms.

Category	Symptoms	No Symptoms
General	Appetite change Fatigue Fever Sweats Weight loss Weight gain Weakness	○
Skin	Itching Rash Mole change	○
Eyes	Vision change Cataracts Glaucoma	○
Ears/Nose/Mouth	Dizziness Ringing in ears Sore throat Runny nose Nosebleeds	○
Lungs	Cough Shortness of breath Chest pain Coughing up blood Wheezing	○
Heart	Chest pain Palpitations Fainting	○
GI	Abdominal pain Nausea Vomiting Diarrhea Constipation Jaundice Blood in stool Difficulty swallowing	○
Urinary	Painful urination Increased frequency Urgency Blood in urine Kidney stones	○
Musculoskeletal	Arthritis Stiffness Swelling Weakness Backache	○
Nervous System	Headache Seizure Dizziness Memory loss Numbness/tingling Anxiety Depression Personality change	○
Reproductive	(M) Testicular pain (M) Swelling (W) Pelvic pain (W) Abnormal bleeding	○
Hematologic	Bruising Bleeding Recurring infections	○

DENVER
PARKS & RECREATION

Past History	Family History	Present Symptoms/Conditions
Check if you've had....	*(Including parents, grandparents, siblings) ...*	*Do you experience...*
☐ Rheumatic Fever	*Have any relatives had...*	☐ Chest Pains
☐ Heart Murmur	☐ Heart Attacks	☐ Heart Palpitations
☐ High Blood Pressure	☐ High Blood Pressure	☐ High Blood Pressure
☐ Disease of the arteries	☐ Heart Operations	☐ Cancer
☐ Heart Attack	☐ Congenital Heart Disease	☐ Lymphedema
☐ Chest Pain	☐ Cancer	☐ Shortness of Breath
☐ Stroke	☐ Diabetes	☐ Back Pain
☐ Cancer	☐ Other Major Illness	☐ Arthritis
☐ Lymphedema		☐ Swollen Legs
☐ Lung Disease		☐ Other
☐ Epilepsy		
☐ Diabetes		Are you currently Pregnant?
☐ Varicose Veins		☐ Yes
☐ Injuries to Back		☐ No
☐ Injuries to Knees, etc.		☐ Unsure
☐ Surgery		
☐ Other		

Explain each checked item: ____

____

HOSPITALIZATIONS/SURGERIES

List all reasons you were hospitalized	Year
1. ____________________________	_____
2. ____________________________	_____
3. ____________________________	_____
4. ____________________________	_____
5. ____________________________	_____

ALL ALLERGIES REACTION
(MEDICATIONS/FOODS/ETC)

1. ____________________ ________________
2. ____________________ ________________
3. ____________________ ________________
4. ____________________ ________________
5. ____________________ ________________

I understand that completion of the Health History Questionnaire is required prior to my participation in a Personal Training Program. I certify that all information I have provided on this form is true and accurate. I will notify the program staff of any changes in my health.

NAME:____DATE:____________________

SIGNATURE:____