Fitness
ESSENTIALS

Health History
Intake Form

When you complete this form, please send to:

Fitness Essentials, LLC
7101 Penn Ave.
Pittsburgh PA, 15208

Health/Fitness History

(Confidential Information)

General Information

Referred By | Date

How did you hear about us?

Name (Last) (First) (MI)

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
Allergies	☐	☐
Anemia	☐	☐
Asthma	☐	☐
Arthritis	☐	☐
Bronchitis	☐	☐
Bursitis	☐	☐
Cancer	☐	☐
(Specify type/location)		
Cirrhosis	☐	☐
Claudication	☐	☐
Chronic Cough	☐	☐
Diabetes	☐	☐
Dizziness/Fainting	☐	☐
Emphysema	☐	☐

	Personal	Family
Hypertension	☐	☐
Hypotension	☐	☐
Hepatitis	☐	☐
Heart Condition	☐	☐
(Specify)		
Kidney Disease	☐	☐
Mononucleosis	☐	☐
Osteoporosis	☐	☐
Pneumonia	☐	☐
Respiratory Condition	☐	☐
Rheumatic Fever	☐	☐
Severe Headache	☐	☐
Stroke	☐	☐
Other *(Specify)*		

Medications

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list medication:

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:

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

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

If yes, please explain:

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?

Thank you!

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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

Thank you!