Fitness By Dot

Dot Spaet
Personal Fitness Coach
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Health History Questionnaire

Name: Age: Sex: Today's Date:

Address: Home Phone: Cell or Work Phone:

City: State: Zip: Height: Weight:

Date of Birth: Occupation: Are you pregnant?

How did you hear about us?

Known Diagnosis if any:

How and when did this condition start?

What else have you done to treat this condition?

What success if any have you had with other treatments? Please be specific as to what worked and what did not work:

Do you consider yourself: __ underweight __ overweight __ just right Your weight a year ago

Do you exercise? If Yes, type of exercise: # times/wk or month: Duration:

Other type of exercise: # times/wk or month: Duration:

Do you smoke? If Yes, what (cigarettes, pipe, pot)? #/day or week:

Do you drink alcohol? If Yes, what (beer, wine, liquor)? #/day or week:

Do you drink coffee or tea? If Yes, what (coffee, decaf, black tea)? Cups/day:

Do you drink soft drinks? If Yes, what (cola, sugar-free)? #/week:

Do you drink water? If Yes, what (tap, filtered)? Glasses/day:

Are you dieting? If Yes, type of diet? How long on this diet?

What are your eating habits?

Do you have any known food allergies? If Yes, to what?

List current health problems for which you are being treated:

Indicate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

Are you taking any medications (prescriptions or over-the-counter)? Please specify what and dosage:

Are you taking any supplements? Please specity:

Date of last physical exam: Practitioner name: Phone Number:

Please indicate if you have or have had any of the following:

Past	Present		Past	Present		Past	Present		Past	Present	
__	__	Alcoholism	__	__	Allergies	__	__	Arthritis	__	__	Asthma
__	__	Back Condition	__	__	Bursitis	__	__	Carpal Tunnel	__	__	Diabetes
__	__	Drug Addiction	__	__	Eating Disorder	__	__	Environmental Sensitivities	__	__	Epilepsy
__	__	Fatigue	__	__	Fibromyalgia	__	__	Heart Trouble (any)	__	__	Heart Condition
__	__	Hernia	__	__	High Blood Pressure	__	__	Low Blood Pressure	__	__	Joint Pain
__	__	Migraine	__	__	Nervous Tension	__	__	Osteoporosis	__	__	Sciatica
__	__	Shortness of Breath	__	__	Sinus	__	__	Tight Shoulders	__	__	Ulcers
__	__	Varicose Veins									
__	__	Autoimmune Issues, please specify:									
__	__	Other:				__	__	Other:			

I certify to the best of my knowledge the above information is correct and complete. I also understand that Dot Spaet assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.

Signature: Date:

Signature of Fitness Coach: Date: