

**Butler University
Department of Recreation
Personal Training
Health History Form**

Name (Last, First, M.I.) _____
 Age _____ Sex M F Email: _____
 Physician's Name _____
 Physician's Phone () - _____

Person to contact in case of Emergency:
 Name _____ Phone () - _____
 Are you taking any medications or drugs? If so, please list medication, dose and reason.

Does your physician know you are participating in this exercise program?

Describe any physical activity you do somewhat regularly.

<i>Do you now or have you had in the past:</i>	YES	NO
1. History of heart problems, chest pain or stroke	<input type="checkbox"/>	<input type="checkbox"/>
2. Increased blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition	<input type="checkbox"/>	<input type="checkbox"/>
4. Difficulty with physical exercise	<input type="checkbox"/>	<input type="checkbox"/>
5. Advice from physician not to exercise	<input type="checkbox"/>	<input type="checkbox"/>
6. Recent surgery (last 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
7. Pregnancy (now or within last 3 months)	<input type="checkbox"/>	<input type="checkbox"/>
8. History of breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, joint, or back disorder, or any previous injury still affecting you	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes or thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
11. Cigarette smoking habit	<input type="checkbox"/>	<input type="checkbox"/>
12. Obesity (more than 20% over ideal body weight)	<input type="checkbox"/>	<input type="checkbox"/>
13. Increased blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
14. History of heart problems in immediate family	<input type="checkbox"/>	<input type="checkbox"/>
15. Hernia or any condition that may be aggravated by lifting weights	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "YES" answers in space below

*Assess your health history by marking all **TRUE** statements*

History

You have had:

- a heart attack
- heart surgery
- cardiac catheterization
- coronary angioplasty (PTCA)
- pacemaker/implantable cardiac defibrillator/rhythm disturbance
- heart valve disease
- heart failure
- heart transplantation
- congenital heart disease

If you marked any of the statements in this section, consult your health care provider before engaging in exercise. You may need to exercise at a facility that has a **medically qualified staff**.

Symptoms

- You experience chest pain or discomfort with exertion.
- You experience excessive breathlessness.
- You experience dizziness, fainting, blackouts.
- You take heart medication(s).

Other health issues

- You have musculoskeletal Problems.
- You have concerns about the Safety of exercise.
- You take prescription medication(s).
- You are pregnant.

Cardiovascular risk factors

- You are a man older than 45 years.
- You are a woman older than 55 years or you have had a hysterectomy or you are postmenopausal.
- You smoke.
- Your blood pressure is $\geq 140/90$.
- You don't know your blood pressure.
- You take blood pressure medication.
- Your blood cholesterol level is > 200 mg/dL.
- You take cholesterol-lowering medication.
- You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister).
- You are diabetic or take medicine to control your blood sugar.
- You are physically inactive (i.e., you get less than 30 minutes of moderate-intensity physical activity on most days of the week).
- You are more than 20lbs overweight.

If you marked two or more of the statements in this section, you should consult your health care provider before engaging in exercise. You might benefit by using a facility that has a **professionally qualified exercise staff** to guide your exercise program.

If you marked two or more statements in this section it is required that your physician fill out the *Medical Release Form*. We must have this on file before you can begin your personal training sessions.

- None of the above is true.

You should be able to exercise safely in almost any facility that meets your needs without consulting your health care provider.

Butler University
Department of Recreation
Personal Training
Lifestyle Information Form

Physical Activity

1. In the past year, how often have you been engaged in physical activity?
 Regularly (3 to 4 times/week)
 Semiregular (1 to 2 times/week)
 Sporadic (1 to 2 times/month)
 None
2. What types of physical activity do you consider “fun”? _____
3. What are your personal barriers to exercise (i.e. your reasons for not exercising)?

4. What physical activity have you been successful with in the past (liked and participated regularly)?

5. How do you think your weight affects your daily activities?

Support

6. Do you feel any family, friends, or co-workers have negative feelings (i.e. disapproval, resentment) toward your efforts at physical activity?

7. Is your significant other or a close friend involved in any regular physical activity?

Occupation/Leisure

8. What is your present occupation? _____
9. Does your occupation require much activity (i.e. walking, carrying things, getting up and down)? _____
10. What are your usual leisure activities?

Stressors

11. What types of things make you feel stressed? _____
12. How do you normally deal with your stress? _____

Dietary Patterns

13. How many meals and/or snacks do you have per day? _____
14. What would you estimate your caloric intake to be per day? _____
15. Do you feel you eat healthy “most of the time”? _____

Expectations

16. Specifically describe what you would like to accomplish through your fitness program during the next:
1 month _____
4 months _____
1 year _____

Butler University
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Personal Training
Health Status Questionnaire

Name (Last, First, M.I.) _____ Phone(H) () -
 Address _____ Emergency Contact _____
 _____ Emergency Phone () -
 City _____ Zip _____ Personal Physician _____
 DOB / / Age ____ Sex M F Physician's Phone () -
 Email: _____

SECTION I) MEDICAL HISTORY

1. Mark any of the following for which you have been diagnosed or treated:
 Kidney problem Heart problem Phlebitis Concussion
 Mononucleosis Cirrhosis, liver Stroke Asthma

2. Mark any medications taken in the last 6 months:
 Blood thinner Epilepsy medicine Nitroglycerin Diabetes medicine
 Heart rhythm medicine Insulin Blood pressure medicine
 Diuretic (water pill) Digitalis Cholesterol medicine
 Other _____

3. List any surgeries you have had in the past (i.e. knee, heart, back, etc.):

4. Have you ever had **back problems**, any problems with **joints** (knee, hip, shoulder, elbow, neck), or been diagnosed with **arthritis**? _____ If yes, describe:

5. Do you have **any other medical conditions** or health problems that may affect your exercise plan or safety in any way? _____ If yes, describe: _____

SECTION II) CARDIOPULMONARY AND METABOLIC SYMPTOMS

- Y N Do you ever get unusually **short of breath** with every light exertion?
 Y N Do you ever have **pain, pressure, heaviness, or tightness** in the chest area?
 Y N Do you regularly have **unexplained pain** in the abdomen, shoulder, or arm?
 Y N Do you ever have **dizzy spells** or episodes of fainting?
 Y N Do you ever feel **“skips,” palpitations**, or runs of fast or slow heart beats in your chest?
 Y N Has a physician ever told you that you have a **heart murmur**?
 Y N Do you **regularly** get lower leg pain during walking that is relieved with rest?
 Y N Do you have any joints that **often** become swollen and painful?
 Where? _____

SECTION III) CARDIOPULMONARY/METABOLIC DISEASE

- Y N Have you ever had a **heart attack, bypass surgery, angioplasty**, or been diagnosed with **coronary artery disease** or other heart disease? _____
If yes, describe: _____
- Y N Do you have **emphysema, asthma**, or any other chronic lung condition or disease? _____
- Y N Are you an **insulin dependent diabetic**? _____

SECTION IV) CORONARY RISK FACTOR PROFILE

- Y N Have you had **high blood pressure** (≥ 140 systolic or ≥ 90 diastolic) on more than one occasion? _____
Please list any **medications** you take for high blood pressure: _____
- Y N Have you ever been told that your blood **cholesterol** was high (200 mg/dL or higher)? _____ Cholesterol level _____
- Y N Do you currently **smoke** 10 or more cigarettes per day?
_____ **cigarettes/day** _____ **years smoked**
- Y N Have you ever been told that you have **high blood sugar** or **diabetes**? _____
- Y N Has anyone in your **immediate family** (parents, siblings) had any heart problems or coronary disease before age 55? _____ Describe: _____
- Y N Do you feel you are more than 20 lbs overweight? _____ What do you feel is your realistic, ideal weight? _____

SECTION V) FITNESS

Circle the average number of times per week you participate in planned moderate-to-strenuous exercise of at least 20 minutes duration (brisk walking, jogging, cycling, swimming, stair climbing, weightlifting, active sports such as tennis, aerobic classes, etc.).

0 1 2 3 4 5 6 7 8 9 10

- Y N Can you briskly walk 1 mile without fatigue? _____
- Y N Can you jog 2 miles continuously at a moderate pace without discomfort? _____
- Y N Can you do 20 push-ups? _____
- Please list your body weight:
Now _____ lbs 1 year ago _____ lbs Age 21 _____ lbs

SECTION VI) LIFESTYLE AND BEHAVIORAL

1. Describe any **aerobic exercise** you have done in the past (what, when, how often, for how long). _____

2. Describe any **muscular strength/weight training** you have done in the past (same as above). _____

3. List any major **obstacles** that you feel will have to overcome to stick with your exercise plan long-term (i.e. what has stopped you in the past)._____

4. Have you ever participated in **aerobics** or **aerobic step** classes? Yes No

5. Please list any recreational physical activities (tennis, golf, etc.) in which you regularly participate and how often. _____

6. List any **favorite** activities you would like to include in your exercise plan. _____

7. List any activities that you definitely **do not like** and do not want to include. _____

8. Which do you prefer? Group exercise Exercising on your own

9. List the 2 most important goals or reasons why you want to exercise regularly. _____

10. Your occupation _____

11. Do you spend more than 25% of work time at the following (mark all that apply)?

Sitting at a desk Lifting/carrying loads Standing

Driving Walking

12. Number of **hours** worked per week ___ Hours Any flexible hours? Yes No

13. Write in the best exercise times for you during a **typical week**.

	M	Tu	W	Th	F	Sa	Su
AM							
PM							

14. Where do you plan to exercise? HRC Home Outdoors

Other _____

15. If at home, list all available equipment _____

Butler University
Department of Recreation
Personal Training
PAR-Q

Regular physical activity is fun and healthy and increasing more people are starting to become more active every day. Being more active is very safe for most people. However some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly:

Check YES or NO

YES NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said that you have a heart condition <i>and</i> that you should only do physical activity recommended by a doctor? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel pain in your chest when you do physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you had chest pain when you were not doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose your balance because of dizziness or do you ever lose consciousness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart conditions? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you know of <i>any other reason</i> why you should not do physical activity? |

If you answered YES to one or more questions:

- > Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.
- > You may be able to do any activity you want – as long as you start slowly and build up gradually. Or you may need to restrict your activities to those that are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- > Find out which community programs are safe and helpful for you.

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- > Start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- > Take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94 talk with your doctor before you start becoming much more physically active.

Delay becoming much more active:

- > If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- > If you are or may be pregnant – talk to your doctor before you start becoming more active.

Please Note: *If your health changes so that you then answer YES to any of the above questions tell your fitness or health professional. Ask whether you should change your physical activity plan.*

Informed Use of the PAR-Q

Butler University, the Department of Recreation and their agents assume no liability for person who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name (Last, First, M.I.) _____

Signature _____ Date: / /

Witness (Personal Trainer) _____

Note: *This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.*

Cancellations must be made 24 hours prior to session. Sessions canceled with less than 24 hours notice are forfeited.