Health History Questionnaire

Please answer the following questionnaire to the best of your ability. As is customary, all of your responses are completely confidential and may only be used in group summaries and/or reports. All information collected is subject to the Privacy Act of 1974. If you have any physical handicaps or information that would require special assistance with this questionnaire, please let your trainer know. This form is in accordance with the American College of Sports Medicine guidelines for risk stratification when followed correctly by your trainer. Your trainer should be certified with a national organization in order to use these forms correctly.

Name: Height: Weight:

Gender: Age: Birthdate:

Address:

City: State: Zip: Phone:

Emergency Contact: Phone:

Personal Physician: Phone:

E-mail:

Have you ever had a definite or suspected heart attack or stroke?

- ◯ Yes
- ◯ No

Have you ever had coronary bypass or any other type of heart surgery?

- ◯ Yes
- ◯ No

Do you have any other cardiovascular or pulmonary (lung) disease; other than asthma, allergies or mitral valve prolapse?

- ◯ Yes
- ◯ No

Do you have a history of diabetes, thyroid kidney, liver disease?

- ◯ Yes
- ◯ No

Have you ever been told by a health professional that you have had an abnormal resting or exercise (treadmill) electrocardiogram (EKG)?

- ◯ Yes
- ◯ No

If you answered YES to any of the questions above, please describe:

Do you currently have any of the following:

- ☐ pain or discomfort in the chest or surrounding areas that occurs when you engage in physical activity
- ☐ shortness of breath
- ☐ unexplained dizziness or fainting
- ☐ difficulty breathing at night except in upright position
- ☐ swelling of the ankles (recurrent and unrelated to injury)
- ☐ heart palpitations (irregularity or racing of the heart on more than one occasion)
- ☐ pain in the legs that causes you to stop walking (claudication)
- ☐ known heart murmur

Have you discussed any of the above with your personal physician?

- ◯ Yes
- ◯ No

Are you pregnant or is it likely that you could be pregnant at this time?

- ◯ Yes
- ◯ No

If yes, when is your expected due date?

Have you had surgery or been diagnosed with any disease in the past 3 months?

- ◯ Yes
- ◯ No

If yes, please list date and surgery/disease

Have you had high blood cholesterol or abnormal lipids within the past 12 months or are you taking medication to control your lipids?

- ◯ Yes
- ◯ No

Do you currently smoke cigarettes or have you quit within the past 6 months?

- ◯ Yes
- ◯ No

Have your father or brother(s) had heart disease prior to age 55 OR mother or sister(s) had heart disease prior to age 65?

- ◯ Yes
- ◯ No

Within the past 12 months, has a health professional told you that you have high blood pressure (systolic > 140 OR diastolic >90)

- ◯ Yes
- ◯ No

Currently, do you have high blood pressure or within the past 12 months, have you taken any medicines to control your blood pressure?

- ◯ Yes
- ◯ No

Have you ever been told by a health professional that you have a fasting blood glucose greater than or equal to 110 mg/dl?

- ◯ Yes
- ◯ No

Describe your regular physical activity or exercise program:

Type:

Frequency: (days per week)

Duration: (minutes)

Intensity: (low, moderate, high)

BMI:

If you answered YES to any of the above questions, please describe:

Are you currently under any treatment for any blood clots?

- ◯ Yes
- ◯ No

Do you have problems with bones, joints or muscles that may be aggravated with exercise?

- ◯ Yes
- ◯ No

Do you have any back/neck problems?

- ◯ Yes
- ◯ No

Have you been told by a health professional that you should not exercise?

- ◯ Yes
- ◯ No

Are you currently being treated for any other medical condition by a physician?

- ◯ Yes
- ◯ No

Are there any other conditions (mitral valve prolapse, epilepsy, history of rheumatic fever, asthma, cancer, anemia, hepatitis, etc) that may hinder your ability to exercise?

- ◯ Yes
- ◯ No

During the past 6 months, have you experienced any unexplained weight loss or gain (greater than 10 pounds for no known reason)?

- ◯ Yes
- ◯ No

If you have answered YES to any of the questions above, please describe:

Please list below all prescriptions and over-the-counter medications you are currently taking: (medicine, reason for taking, dosage, frequency)

Are there any medicines that your physician has prescribed to you in the past 12 months which you are currently not taking?

- ◯ Yes
- ◯ No

If so, please list:

I have answered the Health History Questionnaire questions accurately and completely. I understand that my medical history is a very important factor in the development of my fitness/wellness program. I understand that certain medical or physical conditions which are known to me, but that I do not disclose to my trainer, may result in serious injury to me. If any of the above conditions change, I will immediately inform my trainer of those changes. I, knowingly and willingly, assume all risks of injury resulting from my failure to disclose accurate, complete and updated information in accordance with the attached questionnaire. I also understand that in order to properly risk stratify my Health History Questionnaire, my trainer should have a minimum of a national certification as a personal trainer. My trainer also verbally explained this statement to my me and to my understanding.

Client's Signature:

Date:

Trainer's Signature

Date:

For Use by the Personal Trainer ONLY

Check the identified ACSM major coronary risk factors below:

_____ Lipids (TCH ≥ 200 OR HDL < 35)
_____ Family History
_____ Diabetes/glucose ≥ 110 mg/dl
_____ BMI ≥ 30
_____ Metabolic Disease
_____ Signs or Symptoms of Cardiovascular Disease
_____ Cardiovascular Disease
_____ Cigarette Smoking (or quit within the past 6 months)
_____ High Blood Pressure/Blood Pressure Medications
_____ Sedentary
_____ Pregnancy
_____ Respiratory Disease (asthma, emphysema, chronic bronchitis)

Risk Stratification	**Factors**
_____ Apparently Healthy	One or No Risk Factors (No medical clearance required)
_____ Apparently Healthy Male ≥ 45; Female ≥ 55	One or No Risk Factors (Initial medical clearance required)
_____ High Risk, No Signs or Symptoms	Two or More Risk Factors (medical clearance required)
_____ High Risk, with Signs and Symptoms	One or More Signs/Symptoms With or Without Risks (medical clearance required)
_____ Known Disease	Diagnosed Cardiopulmonary/Metabolic Disease (annual medical clearance required)
_____ Pregnancy	Medical Clearance Required

All clients needing written medical clearance from their personal physician must give it to their trainer prior to beginning their exercise program.

Additional Comments: _____

Health History Questionnaire follows the American College of Sports Medicine recommendations for risk stratification. This must be performed on all clients in order to determine the need for medical clearance and/or exercise modifications. Any trainer or those making exercise recommendations should be certified in the proper use of the risk stratification process through a national organization.

If a client has a YES response to anything on page 1, he/she has KNOWN DISEASE, and must have medical clearance prior to beginning exercise.

If he/she has a YES response to anything on #7 a-h on page 2, your client is HIGH RISK WITH SIGNS/SYMPTOMS and must have medical clearance prior to exercise. If your client has a YES response to questions # 8 or 9, he/she must have medical clearance.

YES responses to two or more on questions 10-16 on page 2, your client is HIGH RISK WITHOUT SIGNS OR SYMPTOMS and must have medical clearance (unless he/she also has a YES answer in question #7 making them still HIGH RISK WITH SIGNS/SYMPTOMS).

All other questions on page 3 are at your own discretion. Remember, **when in doubt, refer out.** Please also refer to the most recent edition of *ACSM's Guidelines for Exercise Testing and Prescription* (Williams & Wilkins) as well as the most recent edition of the *ACE Personal Trainer Manual* (American Council on Exercise) for more explanations on the risk stratification. It is your responsibility as a trainer to remain updated on all changes or modifications for risk stratification in determining the need for medical clearance and exercise modifications/recommendations.

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404-406-2873
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American Council on Exercise
4851 Paramount Dr.
San Diego CA 92123
800-825-3636
www.ACEfitness.org

Cancellation Policy

I understand that personal training packages purchased or given as a gift expire 3 months from date of purchase. (___)initial

I understand that if I cancel within 24 hours of an appointment I will be billed for the session unless for the following reasons:

1. Any emergency or illness involving the client will not be billed. Last minute meetings, doctor appointments etc are not considered emergencies and will be billed as a late cancellation. (___)initial
2. If a cancellation is made 24 hours prior to an appointment and another time is available on the trainer's schedule, a client may reschedule without any additional cost. (___)initial

I understand that if I withdrawal from the personal training program for any reason, the following policy applies:

1. By notifying the Program Director prior to the second session a reimbursement will be provided for the remaining sessions. (___)initial
2. If you go over two or more sessions, a refund will only be granted if the client is in an accident, severe illness or is relocating. In these cases a prorated refund will be given for the remaining sessions. (___)initial

Non-YMCA Personal Trainer Policy

Based on the recommendations of the National YMCA of the USA, and due to the fact that personal training services are offered by the YMCA, outside personal trainers are not able to utilize YMCA facilities for their services.

The YMCA of Greater Charlotte definition of personal training is any behavior perceived as one-on-one coaching, fitness training, and/or counseling that involves payment or a "trade-out" (i.e. personal training given and client provides something in return) for services.

I understand that individuals receiving/giving instruction through Personal Trainers not employed by the YMCA of Greater Charlotte may have their memberships suspended or terminated.

I understand that if I choose to assist a friend or family member in working out within the YMCA of Greater Charlotte, I accept full responsibility and liability for any injury that may occur as a result of my assistance.

By signing this form, I am verifying that I am not receiving any compensation (i.e. money, goods or services) for assisting my friend or family member.

Printed Name_____

Signature_____ Date_____

Trainer _____ Date_____

Informed Consent for Exercise Participation

I desire to engage voluntarily in the YMCA exercise program in order to attempt to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory system and to thereby attempt to improve its function. The reaction of the cardiorespiratory system to such activities cannot be predicted with complete accuracy. There is a risk of certain changes that might occur during or following the exercise. These changes might include abnormalities of blood pressure or heart rate. (___)initial

I understand that the purpose of the exercise program is to develop and maintain cardiorespiratory fitness, body composition, flexibility, and muscular strength and endurance. A specific, exercise plan will be given to me, based on my needs and interests and my doctor's recommendations. All exercise programs include warm-up, exercise at target heart rate, and cool-down. The programs may involve walking, jogging, swimming, or cycling (outdoor and stationary); participation in exercise fitness, rhythmic aerobic exercise, or choreographed fitness classes; or calisthenics or strength training. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by exercise target heart rate and perceived effort of exercise. (___)initial

I understand that it is my obligation to inform the Childress Klein YMCA staff of my symptoms should any develop. I also understand that the staff may reduce or stop my exercise program when findings indicate this should be done for my safety and benefit. (___)initial

I understand that during the performance of exercise, physical touching and positioning of my body may be necessary to assess muscular and bodily reactions to specific exercises, as well as to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above. (___)initial

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program. I also affirm that my questions regarding the exercise program have been answered to my satisfaction. (___)initial

Medical Clearance Waiver

In signing this consent form, I affirm that I have been informed by the Childress Klein Health Center and/or the Childress Klein YMCA personal trainer of the need to obtain a physician's examination and approval prior to beginning this exercise program. (___)initial

I understand that a physician's referral and/or examination are recommended for all participants with any exercise restrictions and for those people over 40 years of age. If I am in this category and without a physician's examination or referral, I acknowledge I have been informed of its importance and accept full responsibility for my health and well-being. (___)initial

Also, in consideration for being allowed to participate in the YMCA exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless the YMCA and its staff members conducting the exercise program or testing from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during, or arising in any way from, the exercise program. (___)initial

Printed Name_____

Signature_____ Date_____

Trainer_____ Date_____