

Health History Questionnaire



Name: _____ Gender: M F Birthdate: _____
Address: _____ City: _____ Zip: _____
Phone:() _____ - _____ Cell:() _____ - _____ Email: _____
Job: _____ Emergency Contact: _____ Phone:() _____ - _____
How did you hear about TPOP Fitness? _____ Tshirt Size: S M L XL
XXL

For most people, physical activity should not pose any problem or hazard. The following questions are designed to identify individuals for whom physical activity might be inappropriate or for whom may require physician consent or advice before exercising.

Common sense is your best guide in answering the following questions. Please read them carefully and answer them *HONESTLY*. Check the box that applies to you and write any additional comments as necessary.

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said you have heart trouble or high blood pressure? If yes, please describe the problem(s) and state the date(s) of diagnosis.

_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you frequently have pains in your heart and/or chest? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you often feel faint or have spells of severe dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you had surgery within the last 12 months? If yes, please indicate each surgery and date.
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Are you now or have you been pregnant within the last 3 months? If yes, a physician consent is required. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you diabetic? If yes, circle one: Type I Type II |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have breathing or lung problems? (i.e. Asthma, Chronic Bronchitis, Emphysema, etc.) If yes, please indicate the problem. _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have high cholesterol? Please indicate cholesterol level if known: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you currently smoke? If yes, for how long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Is there a history of heart disease in your family? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have any prior joint injuries? If yes, please indicate each injury and date of incidence.

_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have any prior muscle injuries? If yes, please indicate each injury and date of incidence.

_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you experience any pain or discomfort in your (circle each that applies): back, shoulders, elbows, knees, wrist, ankles? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have arthritis? |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you have any other chronic illness or condition not mentioned above (i.e. Cancer, Lyme's Disease, Fibromyalgia, etc.) If yes, please indicate the condition. _____
_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Does your physician know you are beginning an exercise program? |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Is there a physical reason not mentioned here why you should not participate in an activity program even if you wanted to do so? |

I have read, understood and completed this Health History Questionnaire. All questions were answered truthfully and to my full satisfaction.

Signature: _____ Date: _____

Medicine Questionnaire



Name: _____ Date: _____

Medications, prescribed or over the counter, can affect your response to exercise as well as your heart rate and blood pressure. These effects could result in short term discomfort to potentially fatal symptoms. Sometimes your exercise program may be dictated by when you take your medication. It is important that we understand any medication you may be taking in order to design your exercise program accordingly. Please indicate any medication that you are taking whether prescribed by a physician or self-prescribed. In the event of an emergency during your program with Training Peoples on Physical Fitness, LLC d/b/a TPOP Fitness, this list may be disclosed to the emergency care providers.

Medication	Purpose of Medication	Time of Day

I have read, understood and completed this Prescription Medicine Questionnaire. All questions were answered truthfully and to my full satisfaction. I have discussed with my physician and understand how an exercise program will affect my medication.

Client Consent

I understand that the purpose of participating in an exercise program is to improve my health and physical fitness. I, also, understand that there is a risk of changes to my cardiorespiratory system that can't be predicted. Such changes may include raised blood pressure, increased heart rate, and in rare instances, fatality.

I understand that I am responsible for monitoring my body throughout any physical activity, and that I will cease participation and inform my instructor if I experience any symptoms of concern, including, but not limited to dizziness, light-headedness, nausea, chest pain, joint pain, etc.

In the event that my instructor requires medical clearance before I participate in either a fitness assessment or exercise program, I agree to contact my physician and get the necessary written permission prior to beginning any program.

I agree to participate in an exercise program and agree to assume all risks of my actions. I further agree to not hold Training People on Physical Fitness, LLC d/b/a TPOP Fitness or its employees responsible for 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.

I have read in its entirety, understand, and acknowledge the implications of this consent form.

Signature: _____ Date: _____