

**Perfect Fit**



**Personal Training™ &  
Get Fit "Boot" Camp™**

**Perfect Fit Personal Training  
Health History Questionnaire**

**Client Name:** \_\_\_\_\_

*Do you suffer from any back problems, sensitive to touch/pressure or have tension, soreness or numbness, stiffness in any area?*

*Do you experience frequent headaches?*

*Are you pregnant?*

*Do you have high blood pressure or cholesterol, what was last reading?*

*Have you ever had surgery or broken bones, what for and when?*

*Do you experience fatigue or lack of energy or difficulty sleeping?*

*Do you experience cold hands or feet?*

*Have you ever been advised by a physician to avoid any type of exercise?*

*Do you (or someone in your immediate family) have a cardiac condition, what condition and how old were they when they were diagnosed?  
Do you have any allergies, smoked or live with a smoker?*

*On a scale of 1 to 10 (1=no stress, 10=a lot of stress), please rate the amount of stress in your personal life and your career.*

*Are you taking any medications and for what condition?*

*Do you drink coffee? If so, how much?*

*What time do you usually go to bed at night and wake in the morning?*

*How much do you spend time in a seated position?*

*How many meals do you eat each day? List the number and time of day you usually eat these meals.*

*Do you have any known diseases?*

*Are there any other health issues not previously mentioned?*

*Client Signature : \_\_\_\_\_*

*Date : \_\_\_\_\_*