# Personal Wellness Profile

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, whom may we contact?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary physician (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (phone): \_\_\_\_\_\_\_\_\_\_\_\_\_ (fax):

Date of your last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_

**STATUS AND HISTORY**

Have you had or do you presently have any of the following conditions? (Check if yes.)

\_\_\_ Cancer

\_\_\_ Rheumatic fever

\_\_\_ Recent operation

\_\_\_ Edema (swelling of ankles)

\_\_\_ High blood pressure

\_\_\_ Low blood pressure

\_\_\_ Seizures

\_\_\_ Lung disease

\_\_\_ Heart attack

\_\_\_ Fainting or dizziness (with or without physical exertion)

\_\_\_ Diabetes

\_\_\_ High cholesterol (total): \_\_\_\_ (HDL): \_\_\_\_ (LDL): \_\_\_\_

\_\_\_ High blood sugar (glucose)

\_\_\_ Orthopnea (the need to sit up in order to breathe comfortably) or paroxysmal nocturnal dyspnea (sudden, unexpected shortness of breath at night)

\_\_\_ Shortness of breath at rest or with mild exertion

\_\_\_ Chest pains

\_\_\_ Palpitations or tachycardia (unusually strong or rapid heartbeat)

\_\_\_ Intermittent claudication (calf cramping)

\_\_\_ Pain or discomfort in the chest, neck, jaw, arm, or other area (with or without physical exertion)

\_\_\_ Known heart murmur

\_\_\_ Unusual fatigue or shortness of breath with usual activities

\_\_\_ Temporary loss of visual acuity or speech or short-term numbness or weakness in one side, arm, or leg of your body

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Orthopedic issues (problems with any of the following):

🞏 foot 🞏 ankle 🞏 knee 🞏 hip 🞏 back 🞏 neck 🞏 shoulder 🞏 elbow 🞏 wrist 🞏 hand

\_\_\_ If taking medications, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any (or any other) conditions that may interfere with exercising? 🞏Yes 🞏No

If yes, please describe briefly:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? 🞏Yes 🞏No

If yes, how much per day, and what was your age when you started?

How much per day: \_\_\_\_\_\_ Age: \_\_\_\_\_\_

**FAMILY HISTORY**

Have any of your first-degree relatives (i.e., parent, sibling, or child) experienced any of the following conditions? (Check if yes and indicate the age at which the condition occurred.)

\_\_\_ Heart arrhythmia

\_\_\_ Heart attack

\_\_\_ Heart operation

\_\_\_ Congenital heart disease

\_\_\_ Premature death (before age 50)

\_\_\_ Significant disability secondary to a heart condition

\_\_\_ Marfan syndrome

\_\_\_ High blood pressure

\_\_\_ High cholesterol

\_\_\_ Diabetes

\_\_\_Other major illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain checked items:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ACTIVITY HISTORY**

1. What is your current level of physical activity?

🞏Sedentary 🞏Active lifestyle 🞏Currently exercising 🞏Competitive athlete

2. Do you currently participate in a regular exercise program?

🞏Yes 🞏No If yes, describe briefly:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What is your body weight now? \_\_\_\_ What was it one year ago? \_\_\_\_ At age 21? \_\_\_\_

4. Do you feel that you are overweight? 🞏Yes 🞏No

If so, by how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you follow, or have you recently followed, any specific dietary intake plan, and in general how do you feel about your nutritional habits?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you ever performed cardiorespiratory (aerobic) training exercise? 🞏Yes 🞏No

7. Have you ever performed resistance training exercise? 🞏Yes 🞏No

8. List, in the order of importance to you, your personal health and fitness objectives.

a. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Have you ever worked with a personal trainer? 🞏Yes 🞏No