

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)

From M.A. Nutting, 2019, *The business of personal training* (Champaign, IL: Human Kinetics); Adapted, with permission, from NSCA, 2012, Client consultation and health appraisal, by T.K. Evetovich and K.R. Hinnerichs. In *NSCA's Essentials of personal training*, 2nd ed., edited by J. Coburn and M. Malek (Champaign, IL: Human Kinetics). 171-172 .

- ___ 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:

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