Medical & Health History

HEALTH STATUS QUESTIONNAIRE · NEW CLIENT INTAKE

This is the fuller picture behind your screening form. Answer every question as accurately as you can so your trainer can make an informed assessment. If you are unsure about an answer, leave it and ask at your first session — please don't guess.

> Tick the box beside a question to answer **yes**; leave it blank for **no**. Your responses are held in confidence and shared with no one outside Body by Design.

FULL NAME _____

DATE OF BIRTH _____

TODAY'S DATE _____

HEIGHT _____

WEIGHT _____

BLOOD PRESSURE, IF KNOWN _____

Heart, lungs & circulation

- ☐ Any prior history of heart disease
- ☐ Chest pain or discomfort during exertion
- ☐ Unaccustomed shortness of breath during light activity
- ☐ Dizziness or fainting spells
- ☐ Severe pain in the leg muscles while walking
- ☐ Currently treated for high blood pressure
- ☐ Family history of heart or lung disease before age 55
- ☐ Metabolic disease of the thyroid, kidney or liver
- ☐ A known heart murmur
- ☐ Rapid, throbbing or fluttering heartbeat
- ☐ Difficulty breathing when lying down or at night
- ☐ Swelling of the ankles
- ☐ High blood pressure measured on two or more occasions
- ☐ Cholesterol measured above the healthy range
- ☐ An abnormal EKG or chest x-ray
- ☐ Diabetes — note how many years .....

Conditions you have had or currently have

- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Low blood pressure
- ☐ Arthritis
- ☐ Rheumatic fever
- ☐ Asthma
- ☐ Bursitis
- ☐ Chronic headaches or migraines
- ☐ Bronchitis

- [ ] Emphysema
- [ ] Other lung problems
- [ ] Swollen or painful joints
- [ ] Limited range of motion
- [ ] Persistent fatigue
- [ ] Back problems
- [ ] Shoulder problems
- [ ] Knee problems
- [ ] Foot problems
- [ ] Recently broken bones
- [ ] Hernia
- [ ] Stomach problems
- [ ] Anemia
- [ ] Currently pregnant
- [ ] Other .....

DETAILS ON ANYTHING TICKED ABOVE

Current medications & supplements

MEDICATION OR SUPPLEMENT	DOSAGE	REASON FOR TAKING IT

- [ ] Diuretics
- [ ] Vasodilators
- [ ] Calcium channel blockers
- [ ] NSAIDs / anti-inflammatories
- [ ] Diabetes medication or insulin
- [ ] Beta blockers
- [ ] Alpha blockers
- [ ] Other cardiovascular
- [ ] Cholesterol medication
- [ ] Other — listed in the table above

Surgeries & injuries

List any surgery, fracture, or injury — recent or long past — that still affects how you move, with the approximate year.

Allergies & sensitivities

MEDICATION ALLERGIES

FOOD, ENVIRONMENTAL OR OTHER

Family history

Tick anything a parent or sibling has experienced.

- ☐ Heart attack or heart surgery before age 55
- ☐ Stroke before age 50
- ☐ Congenital heart disease
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Obesity
- ☐ Asthma
- ☐ Leukemia or cancer before age 55

Lifestyle

TOBACCO

- ☐ Never smoked
- ☐ Current smoker — per day _____
- ☐ Former smoker — quit _____

Years smoked in total _____

ALCOHOL

Drinks per week, on average _____

DAILY STRESS LEVEL

- ☐ Low
- ☐ Moderate
- ☐ High — and I enjoy the challenge
- ☐ High — sometimes hard to handle

EATING HABITS — TICK ANYTHING THAT SOUNDS LIKE YOU

- ☐ I seldom eat red or high-fat meals
- ☐ I follow a lower-fat diet
- ☐ My diet includes plenty of high-fiber food
- ☐ I eat five or more servings of fruit and vegetables a day
- ☐ I eat a full breakfast most mornings
- ☐ I rarely eat high-sugar or high-fat desserts

Current symptoms or concerns

Anything you are feeling right now — pain, fatigue, stiffness, shortness of breath — and anything your doctor has restricted.

Physician

NAME & PRACTICE

PHONE

DATE OF LAST PHYSICAL

Emergency contact

NAME & RELATIONSHIP

PHONE

ALTERNATE PHONE

The information above is accurate and complete to the best of my knowledge. I will tell my trainer if anything changes.

CLIENT SIGNATURE

DATE

Thank you for taking the time to complete this — it means your first session can be spent training rather than on paperwork.