Form 3

Personal Wellness Goals Form

This questionnaire is designed to help identify specific wellness goals that can help pinpoint the most effective and efficient program for you.

AREAS I WANT TO IMPROVE:

( ) Aerobic endurance
( ) Muscular endurance
( ) Flexibility
( ) Reflexes
( ) Speed
( ) Power
( ) Improve balance & coordination
( ) Improve eating habits
( ) Body weight: Loss_____ Gain____
( ) Other (specify):_____

( ) Specific sport ability/job ability_____
( ) Injury rehabilitation
( ) Back problem
( ) Physique
( ) Sleep better more___ less___
( ) Improve self esteem
( ) Improve posture
( ) Reduce blood pressure
( ) Lower % body fat

Improving my fitness and wellness levels is extremely important to me because:

_____

_____

Have you participated in a fitness/wellness program before? If yes, please describe:

_____

_____

I was most successful in my fitness or weight loss programs when...

_____

_____

I am committing myself to my fitness/wellness program because otherwise I would have to live with the following unbearable consequences (ex. low self-esteem, limited success, dependency upon others, etc.)

_____

_____

_____

_____

Participant date

Reviewed by:

Form 4-1

Health History Questionnaire

PERSONAL INFORMATION Date:_____

Name:_____ Phone (H) _____

Address:_____ Phone (O)_____

_____

D.O.B. _____ Height:_____ Weight (current)_____ (1 yr. Ago)_____

Have you exercised within the past 6 months? ❑ YES ❑ NO

Type of exercise:_____

_____

Are you dieting? ❑ YES ❑ NO Type:_____

Eating habits:_____

_____

_____

Packs cigarettes smoked/week_____ Alcoholic drinks consumed/week_____

Cups of coffee or tea consumed/day_____ Cans cola drinks consumed/day_____

HEALTH HISTORY

Indicate any diseases or illnesses you have had or currently have:

❑ Asthma	❑ Allergies	❑ Arthritis
❑ Back Condition	❑ High Blood Pressure	❑ Low Blood Pressure
❑ Bursitis	❑ Fatigue	❑ Joint Pain
❑ Ulcers	❑ Heart Condition	❑ Hemorrhoids
❑ Hernia	❑ Nervous Tension	❑ Sinus
❑ Varicose Veins	❑ Epilepsy	❑ Shortness of Breath
❑ Other		

Are you currently taking any medication? ❑ Yes ❑ No

Specify Type & Dosage:_____

When was your last physical examination?_____

Physician's Name_____ Phone: _____

Have you had a stress test? ❑ Yes ❑ No

Cholesterol Profile: HDLs _____ LDLs _____ Total_____

Form 4-2

Health History Questionnaire-2

Goals

Date:_____

- ❑ Lose (Gain) Weight
- ❑ Firm and Tone
- ❑ Improve Cardiovascular Endurance
- ❑ Develop Flexibility
- ❑ Improve Coordination or Sports Related Skills
- ❑ Develop Muscle Bulk
- ❑ Other

Equipment Availability

Time Availability

Miscellaneous Notes

Form 5-1

Health History Questionnaire

Please fill this form out with complete accuracy – it is essential for your safety.

Name:_____ Age:_____ Sex_____ Height:_____ Weight:_____

Address:_____ Work Phone:_____ Home Phone:_____

_____ Occupation:_____

Known Diagnosis, if any _____

Do you have or have you ever had:	YES	NO	
Have you ever been hospitalized			
Heart Attack or Heart Trouble			
Chest Pain or Angina Pectoris			
Coronary Bypass or Angioplasty			
Abnormal or Positive Exercise Stress Test			
Heart Murmur – Noted by a Physician to be			
significant or suggestive of a heart abnormality			
Irregular Heart Beat or Rhythm – Noted by a physician to be significant or suggestive of a heart abnormality			
High Blood Pressure Above 145/95			
Impaired Circulation			
Stroke			
Convulsions or Loss of Consciousness			
Diabetes Mellitus			
High Blood Cholesterol Level			
Are You Pregnant			
Do you smoke or have you ever smoked or used smokeless tobacco for a total of 10 years			

Form 5-2

	Yes	No	
Musculoskeletal Limitations of Movement			
Difficulty Breathing/Shortness of Breath			
Arthritis, Rheumatism			
Knee Problems			
A chronic, recurrent or morning cough			
Any episode of coughing up blood			
Increased anxiety or depression			
Swollen, stiff or painful joints			
Back Pain (Herniated or ruptured Disc)			
Shoulder Pain			
Surgery			

IMPORTANT: If you answered Yes to any of the previous questions, contact your physician as soon as possible.

Your Physician's Name:_____ Phone Number:_____

Address_____

_____

I certify to the best of my knowledge the above information is correct and complete. I also understand that, _____ assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.

Signature_____ Date_____

Signature of IFPA Certified Trainer_____ Date_____

This form may be used by current IFPA Certified Instructors only. Use of this form by anyone not IFPA Certified or an Instructor who has expired is prohibited. No one may change the wording of this form without express written consent of IFPA