Personal Activity Questionnaire

1. How often do you participate in physical activity? ○ Never
○ Occasionally (1-3 times/month)
○ Semi-Regular (1-2 times/week)
○ Regularly (4-5 times/week)

2. For how long do remain active?
○ 20min.
○ 30min.
○ 1 hour
○ Other_____

3. At what intensity are you physically active?
○ Never
○ Low
○ Fairly Low
○ Moderate
○ Somewhat high
○ High

4. What physical or leisure activities do you enjoy?_____
_____
_____
_____

5. What are your personal barriers/challenges to physical exercise?
_____
_____
_____

6. What type of exercise interests you?
○ Cardiovascular machines
○ Walk/run programs
○ Free weights
○ Weight Machines
○ Flexibility training
○ Weight machines
○ Sport skills

7. What is your reason for having a personal trainer?_____
_____

8. Please check which goals apply to you.
- ○ Improved cardiovascular fitness
- ○ Weight loss
- ○ Reshape/tone body
- ○ Improve performance in a sport
- ○ Improve flexibility
- ○ Increase energy
- ○ Increase strength
- ○ Other_____

8. What specific goals do you want to achieve?

_____

_____

9. What motivates you?_____

10. Is there anything else you feel your trainer should know?

_____

_____

_____

11. What are the best days and times for you to workout?

DAYS	TIMES
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

Health History

Participant

Name:_____
Address:_____
Phone:_____Email:_____ Birthdate:_____
Height:_____Age:_____ Gender:_____
OCCUPATION:_____

Primary Health Care Provider

Doctor:_____ Phone:_____
Address:_____

1. Do you Smoke?_____ How often?_____
2. Do you use alcohol?_____ How often?_____
3. Do you have high or low blood pressure? Y or N
4. Do have any cardiovascular problems or disease? Y or N If Y ,explain:_____
   _____
   _____
   _____
5. Have you ever experienced chest pain when doing physical activity? Yes or No
6. Do you lose consciousness or lose balance because of dizziness? Yes or No
7. Are you pregnant or postpartum? Yes or No
8. Do you have diabetes? Y or N, Explain_____
   _____
9. Have you had surgery within the last 2 years? What?
   _____
10. Are you taking any medications (prescribed or not)? Please list:_____
    _____
    _____
11. Are you taking any supplements or vitamins? Please list:_____
    _____
    _____
12. When were you last seen by a physician?
    _____
13. Do you have any injuries or orthopedic problems (bursitis, back problems, knee problems, etc._____
    _____
    _____
14. Have you ever been told you have high cholesterol?_____
15. Please check all conditions that you have or have had in the past.

o Heart attack	o Broken bones	o Arthritis
o Diabetes	o Shortness of Breath	o Swelling of joints
o Stroke	o Anemia	o Anxiety/depression
o Chest discomfort	o Asthma	
o Heart murmur	o Epilepsy	
o Trouble sleeping	o Limited range of motion	
o Migraine or headache	o Fatigue	
o Neck problems	o Hernia	
o Back problems	o Stomach problems	