Mike's Mobile Gym
Medical History Questionnaire

Name (Please Print):_____
First MI Last

Address: _____
Street City/State Zip

Phone: _____/_____/_____
Home Work Cell

Email: _____**Gender:** M F **DOB** ____/_____/_____

Employer: _____**Occupation:** _____

Emergency Contact: _____
Name Relationship Phone

Primary Care Physician: _____
Name Phone

Specialist: _____
Name Phone

How did you hear about us?

Physician Friend/Relative/Member Newspaper/Radio/Flyer

Event/Fair Website On the Road

Other: _____

Interests: (Please circle all that apply)

Personal Training Athletic Training Nutritional Counseling

Weight Loss Rehabilitation Balance/Core

What do you wish to accomplish from your participation in the fitness program?
(Please circle all that apply)

Increase Strength Improve Posture Increase Energy

Increase Cardiovascular Endurance Improve Flexibility Return to Full Activity

Increase Functional Movement (Balance + Core) Reduce Pain Lose Weight: _____lbs

Other: _____

Medical History: (Please check all that apply)

I have / have had this condition: **Medications**

- Coronary Heart Disease _____
- Congenital Heart Disease _____
- Heart Murmurs_____
- Angina (chest pains)_____
- Irregular Heart Beats_____
- Do you have a pacemaker? _____
- Valve problems_____
- Heart Attack_____
- High Blood Pressure_____
- Stroke_____
- Diabetes (type I / type II)_____
- Epilepsy_____
- Cancer (type)_____
- Stomach Ulcers_____
- Lung Disease (COPD, Asthma, Emphysema, etc) _____
- Arthritis: Type_____ Where _____
- Osteoporosis - Hip Score_____ Spine Score _____
- Surgery within last 12 months: When/What Type_____
- Any chronic illness or condition – What Type_____
- Allergies (Please list)_____
- Do you think you may have an infection? _____
- Hernia (or any condition that may be aggravated by lifting weights)_____
- Do you currently smoke? How many years _____ How frequent_____
- Are you a previous smoker? How many years_____ How frequent_____
- Are you pregnant? _____
- Memory Loss/Alzheimer's/Dementia_____
- Other – Please explain _____

  _____

  _____

General Wellbeing (Please check all that apply)

O I receive strength from my spiritual beliefs O I have insomnia/trouble sleeping

O I am very concerned for my overall health O I am stressed

O I feel depressed / energy drained O I experience anxiety

What types of exercises do you regularly do? (Please check all that apply)

O Walking O Running O Biking O Swimming

O Yoga O Tai Chi O Pilates O Elliptical

O Weight-lifting O Racquet Sports O Net Sports O Water Sports

O Other: _____

Please rate your current activity level: (over the last 6 months)

O **None** (No exercise activity)

O **Light** (Slow walking, limited activity, non-structured)

O **Moderate** (Walk 10 – 20 minutes, 2 – 3 times per week, some structured exercise, Some weight training)

O **Heavy** (Walk 30 – 60 minutes, 3 – 4 times per week, structured exercise, consistent Weight training)

Nutrition (Please check all that apply)

O I eat out less than 3 times / week O I seldom eat sweets/junk food

O I rarely eat snacks between meals O I eat 3-5 fruits + vegetables daily

O I eat 3 meals per day O I seldom eat red meats

O I seldom eat fried foods or foods high in fat O I drink at least 48 oz of water daily

Possible Orthopedic Limitations to Exercise (Please check all that apply & list type of injury)

O Neck_____ O Shoulder_____

O Back_____ O Elbow_____

O Hip_____ O Wrist_____

O Knee_____ O Hand_____

O Ankle_____ O Foot_____