# Elite Muscle Mechanics

Health History and Pre-Exercise Questionnaire

Today's Date _____/_____/_____
Name _____ Gender: M F DOB ____/____/____ Age ____
Mailing Address _____ Email _____
Home Phone (_____) ____-_____ Work Phone (_____) ____-_____ Pager/Cell (_____)____-_____
Emergency Contact Person _____ Phone (_____) ____-_____

THANK YOU FOR TAKING TIME TO COMPLETE THIS QUESTIONNAIRE. Please answer each question carefully and completely. This is very important information and will contribute significantly to the development and implementation of your personal MAT and fitness program. If you have any questions please do not hesitate to ask your trainer -_____ Phone (_____) _____-_____

***PART 1 – Medical History***

1. Who are your primary and secondary care medical providers? (Family physician, OBGYN, internist, psychiatrist, chiropractor, etc.) Please include full name, address and reason for seeing the provider.

| Name | Address and Phone | Care Provided |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

2a. Please list any medications you are currently taking. (Use reverse side of page if needed)

| Name of medication | Dosage | Why & How long have you been taking this medication? |
|---|---|---|
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| | | |

2b. Please list any meds you have taken in the past for more than six months but no longer take and why start and stop.

2. Do you take ***any*** nutritional/dietary supplements? If so please list below.

| Name of Supplement | Dosage | Why & How long have you been taking this supplement? |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |

4. Do you now have or in the past suffered from any of the following? :

| | YES | NO |
|---|---|---|
| a. Has your Doctor said or do you have a history of heart problems, chest pain or stroke | | |
| b. Has an immediate family member (parent/sibling) had a heart attack, stroke or cardiovascular disease before the age of 55 yrs old? | | |
| c. Do you frequently have pains in your heart and/or chest when you do physical activity? | | |
| d. Do you lose balance because of dizziness or do you ever lose consciousness? | | |
| e. Is your doctor(s) currently prescribing drugs for blood pressure or heart condition? See Quest #2 | | |
| f. Are you over the age of 65 and not accustomed to vigorous exercise? | | |
| g. High Cholesterol or HDL:LDL imbalance | | |
| h. Do you currently smoke? Cigarette, cigar, pipe smoking How Much How Long | | |
| i. Obesity | | |
| j. Asthma or Breathing trouble | | |
| k. Have you ever had a stroke or heart attack? | | |
| l. Are you a male greater than 45 yrs old? Are you a female greater than 55 yrs old? | | |
| m. (Females) Pregnancy currently or within last 12 months | | |
| How many children have you had? | | |
| n. Learning disabilities or cognitive challenges | | |
| o. Do you consume any alcoholic beverages? (Beer, wine, liquor, etc.) | | |
| Please indicate in ounces how much alcohol you consume weekly (include beer, wine, liquor) | | oz |
| p. Do have difficulty swallowing food or chewing food? | | |
| q. Is there any reason not mentioned thus far to preclude you from regular exercise activity? | | |

Please elaborate here if you checked "yes" for letters a, c, d, j, n, and o.

_____

_____

_____

_____

Do you use any non-prescription drugs (marijuana, cocaine, etc.) _____

5. Please provide your most recent blood panel and any radiological reports you may have from x-rays or MRI's.

***Please complete the following information as completely and thoroughly as possible.***
***This is an extremely important section of this questionnaire.***

6. Trauma/Injury/Surgery History (Every significant physical pain you have experienced) includes even what you might consider minor, non-medically treated injuries.

| ***Body Part*** | 1-18 years | 19 - 29 years | 30 – 45 years | 46 - 60 years | 60 + years |
|---|---|---|---|---|---|
| Head/Jaw i.e. Clicking jaw, concussion, | | | | | |
| Cervical/ Neck i.e. whiplash, | | | | | |
| Thoracic/ Mid back | | | | | |
| Lumbar/ Low back | | | | | |
| Abdominals/ Ribs Hernia | | | | | |
| Pelvis/Hips Femur/Thigh | | | | | |
| Shoulder/ Scapulae/ Rotator cuff | | | | | |
| Elbow i.e. tennis elbow | | | | | |
| Wrist/Hand Fingers Carpal Tunnel | | | | | |
| ***Body Part*** | 1 -18 years | 19 - 29 years | 30 – 45 years | 46 - 60 years | 60 + years |

| | | | | | |
|---|---|---|---|---|---|
| Knees Patella, ACL, Tendonitis | | | | | |
| Ankles/Feet Do you wear Orthotics? | | | | | |

7. Have you had any cosmetic/plastic surgery? Please describe below. (breast augmentation, tummy tuck, botox)

_____

_____

_____

| **8. *Diagnosed Diseases*** **Please Provide all medical reports (X-rays/MRI/CT Scan)** | ***Initial Diagnosis Made*** |
|---|---|
| Orthopedic (i.e. Spinal fusion, Knee joint replacement) | |
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| | |
| Metabolic (i.e. Diabetes, Hypothyroid) | |
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| | |
| | |
| | |
| Neurological (i.e. Stroke, Parkinson's) | |
| | |
| | |
| Dental Work (Braces/Night Bite Plates, Appliances, orthodontics) | |
| | |
| | |
| | |

| 9. What is your Occupation? | How Long Under this Stressor? (In Years) |
|---|---|
| Physical - Sitting, Standing, Positional How Long/Day? _____ | |
| Emotional - Hi Pressure, Boring, Intermittently Hi & Lo Pressure | |

10. ***Please prioritize the severity (#1 is the worst or greatest concern) of your current physical pain/discomfort***

| | |
|---|---|
| #1 | |
| #2 | |
| #3 | |
| #4 | |

11. Please underline all of the following that apply to you - if any:

I don't deserve love
I am shameful
I am not good enough
I cannot succeed
I am weak
I am insignificant (unimportant)
I cannot get what I want
I have to be perfect to please everyone
I did something wrong
I cannot trust anyone
I do not deserve
I am worthless or inadequate
I am not loveable
I cannot trust my judgment
I am not in control
I cannot protect myself
I am a disappointment
I am a failure (will fail)
I am ugly (my body is hateful)
I am in danger
I cannot let it out
I am angry

12. If you feel that you are experiencing unusual levels of stress in one or more of the following areas Please circle 'Yes" if not circle "No":

| | | |
|---|---|---|
| Home | Yes | No |
| Work/School | Yes | No |
| Financial | Yes | No |
| Relational | Yes | No |

13. Please describe a typical day of activity for you.

Example*: "My morning Starts at 6:00 am and I drink a cup of coffee and drive to work. I sit at a desk until noon and order lunch from a local restaurant. I typically work through lunch. I sit at a computer and talk on the phone and end my work day at 6pm. I drive home, pick up my kids and eat dinner around 7pm. I do house chores and am in bed by 11pm."*

Please describe your shoe wear? What do you wear the most throughout the week?

Are you sleeping well?

What are your daily work duties/demands?

14. What physical activities and/or physical positions can you not perform without discomfort or significant tension? (I.e. kneeling down, reaching overhead)

15. What self-care strategies do you currently use to manage your own health and why? (Ice packs, stretching, acupuncture, magnets, heating pad, massage, etc.)

16. Do you play a musical instrument? If so, which instrument, how long, how many hours of practice/week?

17. What have you found to be positions of relief or things you do to manipulate your own body during the day to deal with any pain or discomfort?

18. Do you have confusion or frustrations regarding exercise and wellness strategies – conflicting advice or information you have been given or read yourself?

19. Do you feel that with each passing years you are getting healthier or unhealthier?

20. Please include any additional comments or concerns you may have (use back if needed)

***Part 2 – Fitness and Wellness***

1. Have you consulted with a physician regarding diet and exercise? If yes, please describe the recommendations.

2. Have you in the past, or are you currently following a special diet or eating program? Please describe.

3. What if any, changes would you like to make to your current eating habits?

***If you are currently exercising please answer questions 4 through 10.***

4. Please list and rate the goals for your movement/exercise program as far as how close or far you are from reaching them right now; Circle a number for each goal listed.

| **Your Goals** | **Far** | | | | **half** | **way** | | | | **Done** |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

5. Please describe your current exercise program include;
   How often -
   How long each session -
   Type of exercise –

   Where you exercise -

6. How long have you participated in regular exercise programs?

7. Rate your perception (circle) of the overall effort of your program? (1 - real easy to 10 - real hard)

   1 2 3 4 5 6 7 8 9 10

8. Please rate your exercise participation for each age range through to present age (1 rarely to 10 a lot)

   15 - 20 _____ 21 - 30 _____ 31 - 40 _____ 41 - 50 _____ 51 -60 _____ 60+ _____

9. Were you a high school or college athlete? Please list sports and positions

10. Do you own any exercise equipment? Please list

11. How would you like your goals measured? (Against others in your age/gender, against baseline, etc.)

12. What time frames would you like to plan for each training period goal? (I.e. every 4 weeks, every 3 months)



13. What would you perceive as challenging when you are exercising? How would you know that your individual exercise session is a success each time? (Exhaustion, refreshed, a little sweaty, etc.)

14. What are your expectations for the exercise experience?

15. What do you think would happen if you stopped for 3 – 4 weeks?

16. In what way would you like to receive feedback from the trainer about your progress? (Verbal, written)

17. Have you started exercise programs in the past or joined gyms and stopped? Why?

18. What are the possible reasons you would not complete your training program and embrace exercise as a lifelong, lifestyle, process?

19. What do you believe is necessary in order for you to change your body the way you want? (i.e. eating less, eating more frequently, extremely rigorous exercise, etc.)

20. How would you like to be rewarded, and what is the basis for the reward, when you reach your set goals?