Ron Jones, MS
480 Congress Parkway
Lawrenceville, GA
30044-4579 USA

770.513.9041
(Phone/Fax)
678.227.2566 (Cell)
E-Mail: ron@ronjones.org
Web: www.ronjones.org

Corporate Wellcoaching

Fitness Training & Consulting Services

HEALTH HISTORY QUESTIONNAIRE

Name: Date:

Address: City:

Phone: (Home) (Work) (Cell)

E-Mail: Date of Birth:

Emergency Contact: (Name) (Phone)

Occupation:

Relationship Status:

Children: (# & ages)

Height:

Body Weight & Goals

Current Weight:	Goal Weight:
One Year Ago:	Two Years Ago:
Five Years Ago:	Ten Years Ago:

Fitness Goals:

Nutrition Goals:

Health & Other Goals:

How Can I help You Reach These Goals? ☺

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HEALTH HISTORY: PHYSICAL ACTIVITY

Describe your current level of activity:

Describe any physical activities you have been involved in the last 10 years and their results:

What physical activities do you enjoy?

What physical activities did you enjoy as a child?

What physical activities do you dislike?

What physical activities would you like to try?

What kind of fitness equipment do you own?

Do you currently belong to a health club or gym?

What part of the day is your preference for physical activity?

HEALTH HISTORY: NUTRITION

What are your three ***favorite*** foods?

1. ____
2. ____
3. ____

What are your three ***least favorite*** foods?

1. ____
2. ____
3. ____

How often do you eat fast food?

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HEALTH HISTORY: MEDICAL INFORMATION

For most people, physical activity should not pose any problem or hazard. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.

Common sense is your best guide in answering these questions. Please read them carefully and check the "Yes" or "No" response opposite the question if it applies to you.

Yes	No		
___	___	1.	Has your doctor ever said you have heart trouble? If yes, please describe the problem and state when it was diagnosed. ______________________________ ______________________________
___	___	2.	Do you frequently have pain in your heart or chest?
___	___	3.	Do you often feel faint or have spells of severe dizziness?
___	___	4.	Has a doctor ever told you that your blood pressure was too high?
___	___	5.	Has your doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise or might be made worse by exercise?
___	___	6.	Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to do so?
___	___	7.	Are you over age 65 and/or not accustomed to vigorous exercise?
___	___	8.	Are you or have you ever been a diabetic?
___	___	9.	Are you now pregnant, or have you been pregnant within the last 3 months?
___	___	10.	Have you had any surgery in the last 3 months?
___	___	11.	Have you been hospitalized in the last 2 years? If so, when and why? ______________________________
___	___	12.	Have you ever seen a chiropractor, acupuncturist, or other alternative medicine practitioner? If so, when and why? ______________________________

Please check the box if you have ever experienced any of the following symptoms:

	When first experienced	Treatment used
Pain or discomfort in the chest	___________	___________
Unaccustomed shortness of breath	___________	___________
Dizziness	___________	___________
Labored or uncomfortable breathing, with or without pain	___________	___________
Swollen ankles	___________	___________

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Heart palpitations ________________ ___________________________

Heart murmur ________________ ___________________________

Limping ________________ ___________________________

Yes No Do you have high blood pressure? If yes, what is your current blood pressure without medication?

____

Yes No Are you taking any medication for hypertension? If so, what medication?

____

Yes No Is your total serum cholesterol level over 240?

Yes No Do you smoke?

Yes No Have you ever smoked? If so, when did you quit?

Yes No Do you have diabetes?

Yes No Do you have a family member who has had coronary or atherosclerotic disease before age 55?

Yes No Do you have pain or discomfort in your back?

Yes No Do you have pain or discomfort in your knee? If so, right or left?

Yes No Do you have pain or discomfort in your shoulder? If so, right or left?

Yes No Do you have pain or discomfort in your elbow? If so, right or left?

Yes No Do you have pain or discomfort in your wrist? If so, right or left?

Yes No Do you have pain or discomfort in your ankle? If so, right or left?

If you checked "Yes" above, please describe your pain. On a scale of 1 to 10, with 1 being almost nonexistent and 10 being excruciating, how severe is it? Does it get more or less severe as the day goes on? When do you notice it? What really aggravates it?

____

____

____

____

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Yes No Have you ever torn ligaments or cartilage in your knee? If so, when? _______________

Did you have surgery on this knee? If so, when? _______________________________

Yes No Have you ever dislocated your shoulder? If so, when?

____

Yes No Have you ever had shoulder surgery? If so, which shoulder? When?

____

Yes No Have you ever had a neck injury, such as whiplash? If so, when?

____

Yes No Have you ever been treated for a spinal disk injury? If so, when?

____

Yes No Do you ever experience tingling or numbness in your elbows or hands?

____

What is the present state of your general health? ____

HEALTH HISTORY: PERSONAL

What regular physical activities do you do now? ____

How often? _________________________ For how long each session? ________________________

What part of the day do you prefer to be active? ____

What types of music do you enjoy? ____

Is there any type of music you do NOT like at all? ____

Do you prefer individual and small groups or large groups when exercising? _________________________

Do you like indoor exercise or outdoor exercise? ____

Does temperature bother you when exercising? If so, what type? _________________________________

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HEALTH HISTORY: SIGNATURE PAGE

I, ____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that this information is being provided as part of my initial consultation and may not be periodically updated.

I, ____, assume the risk for any changes in my medical condition that might affect my ability to exercise.

____ ______________________
Signature Date

____ ______________________
Parent/Guardian Signature (if applicable) Date

If you answered yes to one or more questions and you have not recently consulted with your doctor, do so before beginning an exercise program. Tell your doctor which questions you answered yes to and explain that you plan to undergo an exercise program that may include, but may not be limited to, weight and/or resistance training. After medical evaluation, ask your doctor

1. which activities you may safely participate in, and
2. what specific restrictions, if any, should apply to your condition and which activities and/or exercises you should avoid.

I, ____, acknowledge that I have read the foregoing statements and understand the content thereof.

____ ______________________
Client Signature Date

____ ______________________
Parent/Guardian Signature (if applicable) Date

Thank you for taking the time to fill out this form! I coach and train people holistically for Wellness. ***Wellness is "High-Performance Health."*** Wellness is a lifestyle that enables you to make healthy choices. To begin a holistic program that will improve your future health, I need to make a comprehensive evaluation of your medical history and history of experience with physical activity. The information provided on this form will allow me to make an important evaluation of your current health status.

There are no short cuts to Wellness; it's a process that must begin with a solid foundation. A foundation of Wellness is strong and enduring—not weak and short term! Wellness is the right way—period.

You're now on your way to "High-Performance Health." I'm looking forward to helping you to help yourself, *so let's get moving!* ☺

In health,
Ron Jones

"The first wealth is health."
--Emerson

✱ Ron Jones (8-7-04)