

O'Neil Fitness & Personal Training

"For the Best Shape of Your Life!"

978-290-2365

Personal Training

The Boot Camp Workout

Core Conditioning

HEALTH QUESTIONNAIRE/PAR-Q

Name: _____ Date _____

Address _____ City/Town _____

Email _____ T-Shirt Size: _____

Phone No. _____ Alt. Phone No. _____

Date of Last Physical: _____ Age: _____ DOB _____

How did you hear about us? Friend Newspaper Postcard Flyer

Have you ever been diagnosed as having:

Heart trouble	Epilepsy	Thyroid Disorder
Diabetes	Lung disease	Leukemia
High blood pressure	Hyper/Hypoglycemia	Liver/kidney disease
High cholesterol	Anemia	Cancer
Ulcers/digestive problems	Asthma/Respiratory Condition	Cardiovascular disease

Have you recently had:

Chest pain	Lightheadedness/dizziness	Chronic Cough
Shortness of Breath	Blackouts	Coughing of blood
Heart palpitations	Migraines/headaches	Numbness of legs/arms/face

Have any of your immediate family members had:

Heart attacks	Cancer	High cholesterol
Congenital heart disease	Diabetes	Stroke
High blood pressure		

Do you smoke? ____ Are you physically active? ____ Are you pregnant? ____

Please list any areas which you have had pains, injuries, problems or operations. Please indicate if have any joint problems, i.e., knee, hip, ankle, elbow, shoulder, back, etc. **Please list any and all medications** (use back of form if necessary).
