4125 N. 124TH ST, SUITE A, BROOKFIELD, WI 53005 | 262-439-8601
WWW.PEAKPERFORMANCEPROS.COM

Name ____________________
Address ____________________
City ____________________
State ____________ Zip ____________
Email ____________________
Home Phone ____________________
Work Phone ____________________
Cell Phone ____________________
Birthday ____________ Age ____________

Emergency Contact:
Name ____________________
Phone ____________________
Physician ____________________
Phone ____________________

HEALTH HISTORY

On this questionnaire a number of questions regarding your physical health are to be answered. Please answer every question as accurately as possible so that a correct assessment can be made. All responses will be held in strictest confidence.

- Yes • No Do you have any personal history of heart disease?
- Yes • No Have you experienced pain or discomfort in your chest that has not been formally diagnosed?
- Yes • No Have you experienced a rapid throbbing or fluttering of the heart?
- Yes • No Do you have a known heart murmur?
- Yes • No Do you have any unaccustomed shortness of breath?
- Yes • No Do you have any difficulty breathing while standing or have sudden breathing problems at night?
- Yes • No Have you had any problem with dizziness or fainting?
- Yes • No Do you suffer form swelling in the ankles?
- Yes • No Have you ever experienced severe leg pain while walking?
- Yes • No Do you have any history of metabolic disease (thyroid, renal, liver)?
- Yes • No Do you have diabetes? If yes, at what age was onset diagnosed?
- Yes • No Have you been told you have high blood pressure on more than two occasions? Last BP _____/_____
- Yes • No Has you total cholesterol been measured greater than 240mg/dl?
- Yes • No Has your HDL cholesterol been measured greater than 60 mg/dl?
- Yes • No Are you a cigarette smoker?
- Yes • No Do you have any family history of cardiac or pulmonary disease prior to age 55?
- Yes • No Would you describe your lifestyle as sedentary?

List any surgical procedure you have undergone within the last two years or any other surgery that has resulted in complications that limit your current activities.

____
____

Has your Physician ever limited you're activity in any way?

____
____

Please list any medications you are currently taking?

____

Do you have any regular and consistent pain in your

• Feet	• Shins	• Shoulder	• Forearm	• Back
• Knees	• Calves	• Elbow	• Upper Arm	• Neck
• Hips	• Thighs	• Wrist	• Other	

In the space below describe your most recent exercise habits

Activity	Duration	Frequency	Intensity
____________ /	________ /	________ /	________
____________ /	________ /	________ /	________
____________ /	________ /	________ /	________

List Your Current Fitness Related Goals

____
____

Email completed form to: **bob@peakperformancepros.com** & **heather@peakperformancepros.com**