

Gesundheitsfragebogen

Last name: _____
 First name: _____
 Street: _____
 Postal Code/Place: _____
 Home phone: _____
 Work phone: _____
 Mobile: _____
 E-mail: _____
 Date of birth: _____ . _____ . _____
 Profession: _____
 Health insurance: _____

Personal questions

What are your hobbies?
Do you engage regularly in sports? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what sport and how many times a week?
Have you had personal training/fitness training before? <input type="checkbox"/> If yes, when was it, and how many times a week?
<input type="checkbox"/> If no, how long have you been considering starting personal training?
What are your training goals?
How many times per week/month would you be able/willing to make time for Pascal Bollmann AG? <input type="checkbox"/> once <input type="checkbox"/> twice <input type="checkbox"/> 3 times <input type="checkbox"/> more
How/through whom did you become aware of us?
Why have you chosen Pascal Bollmann AG?

I hereby confirm that the information I have provided is accurate and complete:

Date/signature: _____

Health questionnaire

Do you have back problems?	<input type="checkbox"/> yes <input type="checkbox"/> no
Joint problems?	<input type="checkbox"/> yes <input type="checkbox"/> no
Any operations?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you take medications?	<input type="checkbox"/> yes <input type="checkbox"/> no
Complaints involving lower body strain?	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma?	<input type="checkbox"/> yes <input type="checkbox"/> no
Varicose veins?	<input type="checkbox"/> yes <input type="checkbox"/> no
Stress?	<input type="checkbox"/> yes <input type="checkbox"/> no
Bronchitis?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you in the care of a physician?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you in a therapist's care?	<input type="checkbox"/> yes <input type="checkbox"/> no
Any metabolic disorders? (thyroid gland, blood sugar)?	<input type="checkbox"/> yes <input type="checkbox"/> no
Pregnancy?	<input type="checkbox"/> yes <input type="checkbox"/> no
Bladder weakness?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you currently on a diet?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever had an ECG?	<input type="checkbox"/> yes <input type="checkbox"/> no

Risk factors

Age	Over 45	10 <input type="checkbox"/>
	Over 35	4 <input type="checkbox"/>
	Until 35	0 <input type="checkbox"/>
Cardio-vascular	Cardiovascular Heart defect	40 <input type="checkbox"/>
	Heart attack	40 <input type="checkbox"/>
	Dysrhythmia	40 <input type="checkbox"/>
	No cardiac insufficiency	0 <input type="checkbox"/>
Family	Heart attack before 60?	16 <input type="checkbox"/>
	Heart attack after 60?	6 <input type="checkbox"/>
Blood-pressure	High	8 <input type="checkbox"/>
	Not known	4 <input type="checkbox"/>
	Normal	0 <input type="checkbox"/>
Weight	Overweight	4 <input type="checkbox"/>
	Normal weight	0 <input type="checkbox"/>

Total points: _____

36 or more A doctor's visit is recommended
 20-35 Health training
 0-19 No restrictions