

ATHLETE HISTORY QUESTIONNAIRE

PERSONAL EVALUATION

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Fax Number: (\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

At which number can we contact you?  Home  Work  Both

What are the best times to reach you? \_\_\_\_\_

Would you prefer workouts by:  E-mail  Fax  Internet

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Height: \_\_\_\_\_ Weight \_\_\_\_\_

Other personal information:

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Married?  Yes  No Children?  Yes  No

How did you hear about these coaching services? \_\_\_\_\_

## ATHLETE MEDICAL HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Personal Physician: \_\_\_\_\_  
Name: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Address: \_\_\_\_\_ Name: \_\_\_\_\_  
City/State: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Zip: \_\_\_\_\_ Day Phone: (\_\_\_\_) \_\_\_\_\_  
Eve. Phone: (\_\_\_\_) \_\_\_\_\_

### Medical History

Please list any medications taken on a regular basis (prescription and nonprescription):

MEDICATION	DOSE	FREQUENCY	REASON
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### Allergies

Are you allergic to any medications? \_\_\_\_ NO \_\_\_\_ YES

If yes, please explain.

ALLERGIC TO: \_\_\_\_\_ REACTION: \_\_\_\_\_

### Past and Current Medical History

Please list any current illness, recent injuries, recent surgeries, or past medical problems or surgery of note.

	YES	NO	YES	NO
Do you have, or have you had, any of the following?				
Heart disease	_____	_____	Asthma	_____
Heart attack	_____	_____	Wheezing	_____
Heart surgery	_____	_____	Diabetes	_____
Heart murmur	_____	_____	Epilepsy	_____
Hypertension	_____	_____	Anemia	_____
Thyroid problems	_____	_____	Stress fracture	_____

Any special medical needs or information the coach should be aware of?



### CURRENT FITNESS LEVEL INFORMATION

1. What is your waking pulse? \_\_\_\_\_ beats per minute.

1a. Is this high or low for you?    High    Low    Don't know

2. Circle what you feel is your current fitness level compared to your highest fitness level in the past five years. (1 = high, 5 = low)

1            2            3            4            5

3. Describe your current training week. If you keep a training log, include a copy of last week:

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4. Is this  more  less  the same as a normal training week for you?

5. Describe your longest single workout in the last three weeks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. How many hours per week do you spend training now? \_\_\_\_\_

7. Please list exactly when and how much time you have available for training?

MON \_\_\_\_\_ TUES \_\_\_\_\_ WED \_\_\_\_\_ THURS \_\_\_\_\_

FRI \_\_\_\_\_ SAT \_\_\_\_\_ SUN \_\_\_\_\_

8. How many days per week do you take off from training? \_\_\_\_\_

8a. Ideally, how many days would you like to take off from training? \_\_\_\_\_

9. Are you currently recovering from any injury or illness? Explain:  
\_\_\_\_\_  
\_\_\_\_\_

## PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

Please explain any "Yes" answers in the space below.

- Yes  No 1. Has a doctor ever said that you have a heart condition and recommended only medically supervised physical activity?
- Yes  No 2. Do you have chest pain brought on by physical activity?
- Yes  No 3. Have you developed chest pain within the last month?
- Yes  No 4. Do you tend to lose consciousness or fall over as a result of dizziness?
- Yes  No 5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?
- Yes  No 6. Has a doctor ever recommended medication for high blood pressure or a heart condition?
- Yes  No 7. Are you aware, through your own experience or a doctor's advice, of any other physical reasons against your exercising without medical supervision?

Explain:

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Other Health History Questions:

- Yes  No 1. Do you have any metabolic diseases, controlled or uncontrolled, such as diabetes, hyperthyroidism, hypothyroidism, etc.?
- Yes  No 2. Do you, or have you ever, smoked regularly?
- Yes  No 3. Do you take any drugs or medications?
- Yes  No 4. Are you, or have you been, recently pregnant?
- Yes  No 5. Do you have high cholesterol?
- Yes  No 6. Have you had any surgery in the past year?
- Yes  No 7. Have you ever had an injury that caused you to stop exercising for more than one week?
- Yes  No 8. Are you, or have you ever been, anorexic or bulimic?
- Yes  No 9. Are there any other physical or emotional problems that may affect your training?

Explain:

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## RACING AND PERFORMANCE GOALS

List below all the events you plan on possibly competing in this year. We understand this schedule is subject to change (in fact, we may suggest you change it). Please notify us if this schedule does change.

**HIGH-PRIORITY EVENTS** These are the most important events of the racing season to you. There should be only a few of these because we will design your training schedule to taper and peak for them.

Date	Event	Distance(s)	Goal Time/Place
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**MEDIUM-PRIORITY EVENTS** These are events you want to do well, but are not the focus of your season. We may rest for these events, but usually they will be thought of as race pace “workouts” to sharpen up for the high-priority events.

Date	Event	Distance(s)	Goal Time/Place
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**LOW PRIORITY EVENTS** These are events of least importance to you. They are “fillers” to your season and you will most likely compete for fun and for a good workout. Do not include too many of these events, however, as they might detract from the focus of your season.

Date	Event	Distance(s)	Goal Time/Place
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What is your number one goal (be specific) of this season?

**EQUIPMENT AND OTHER INFORMATION**

1. Do you own a heart rate monitor?  Yes  No

1a. If so, what brand and model? \_\_\_\_\_

2. What is the highest heart rate you have noticed while running? \_\_\_\_\_

2a. During cycling? \_\_\_\_\_ 2b. During another sport? \_\_\_\_\_

3. Please check off the equipment that you own or have access to:

- \_\_\_ Triathlon Bike      \_\_\_ Mountain Bike      \_\_\_ Road Bike
- \_\_\_ Resistance Trainer      \_\_\_ Bike Computer (list features: \_\_\_\_\_)
- \_\_\_ Rollerblades      \_\_\_ Running Track (1 lap = ? \_\_\_\_\_)
- \_\_\_ Treadmill      \_\_\_ Pool      \_\_\_ Water Jog Vest
- \_\_\_ Nautilus Type Weights      \_\_\_ Free Weights      \_\_\_ Nordic Track
- \_\_\_ Rowing Ergometer      \_\_\_ StairMaster/Stepper      \_\_\_ Open Water
- \_\_\_ Steep, Short Hill      \_\_\_ Longer, Moderate-grade Hill

4. At the end of this month, how will you judge if your training program is working?  
\_\_\_\_\_  
\_\_\_\_\_

5. At the end of this season, how will you judge if this training program was successful?  
\_\_\_\_\_  
\_\_\_\_\_

6. Why do you train and compete in endurance sports (be honest)?  
\_\_\_\_\_  
\_\_\_\_\_