# Health History

Name:_____ Date of Birth:_____/_____/_____
Address:_____ _____ City/State/Zip:_____
Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____
E-Mail Address:_____

**Emergency Contact:**
Name:_____ Phone Number: (_____)_____-_____
Relationship:_____

***Note:*** *Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other changes in their physical activity levels.*

| **Please Answer the Following Questions with an "X" for "Yes" or "No"** | | | |
|---|---|---|---|
| | | **Yes** | **No** |
| 1 | Are you over the age of 55 and / or not accustomed to vigorous exercise? | ☐ | ☐ |
| 2 | Do you have any reason to suspect that you may be pregnant or have you been pregnant with the last 3 months? | ☐ | ☐ |
| 3 | Have you had any major or minor surgery in the past 3 months? | ☐ | ☐ |
| 4 | Have you been hospitalized in the last 2 years? If yes,<br>When?<br>For what reason? | ☐ | ☐ |
| 5 | Are you currently, or have you in the past, see a chiropractor or physical therapist for any condition? If yes,<br>Describe under what condition? | ☐ | ☐ |
| 6 | Do you currently, or have you ever experienced unexplained heart palpitations or been diagnosed with a heart murmur or irregular heartbeat? | ☐ | ☐ |
| 7 | Is there any history or heart disease (prior to age 55) in your immediate family?<br>If yes, Explain: | ☐ | ☐ |
| 8 | Do you receive regular annual physical exams from your primary care physician?<br>Do you know the date of your last exam? _____/_____/_____ | ☐ | ☐ |

| Please Answer the Following Questions with an "X" for "yes" or "NO" or leave space blank. | | | |
|---|---|---|---|
| | | Yes | NO |
| 1 | Have you ever been diagnosed with high blood pressure? | | |
| 2 | Do you know what your blood pressure is? If Yes, please state _____/ _____ | | |
| 3 | Do you currently smoke? If Yes,<br>How many cigarettes per day? _____ | | |
| 4 | Did you ever smoke? If yes,<br>How long ago did you quit? | | |
| 5 | Do you know your cholesterol levels?<br>If so, please state. HDL _____ LDL _____ Total Cholesterol _____ | | |

| Please check the box of the following areas in which you have any pain, discomfort, or a current/previous injury to: | | | |
|---|---|---|---|
| Right knee | | Left knee | |
| Right shoulder | | Left shoulder | |
| Right elbow | | Left elbow | |
| Right wrist | | Left wrist | |
| Right ankle | | Left ankle | |
| Back | | Neck | |

**If you checked "yes" to any of the discomforted areas, please explain the nature of your pain and/or injury. Are their certain activities or conditions that aggravate the pain and/or injury?

Are there any other health, medical, or other conditions that your trainer should be aware of?
(There is more space at the end of this form)

Please list any prescription medication or over-the-counter medications or supplements you currently take:
(There is more space at the end of this form)

**Please read the following carefully and sign where appropriate:**

**I, _____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that if this information changes in any way in the future, it is my responsibility to notify my personal trainer, and that I assume the risk for any changes in my medical condition that might affect my ability to exercise.**

**Before beginning a new fitness program or other significant change in your activity levels, you are advised to consult with your physician or primary health care provider. Only a physician or qualified health care provider is able to diagnose and prescribe treatment for specific health conditions.**

**I acknowledge that I have read the foregoing statements and fully understand the content thereof, and that if I choose not to consult with my physician or primary health care provider, I do so at my own risk.**

_____ _____

**(Signature)** **(Date)**

_____

**(Print Name)**

_____

**(Parent or legal guardian signature if participant is under 18 years old)**

**Any Other Information**

Breakfast

Snack

Lunch

Snack

Dinner

Snack