Medical History Form

PERSONAL AND CONTACT INFORMATION

First Name_____ Last Name_____

Address _____

Phone (Home/Bus/Cell) _____

Date of Birth_____ Email _____

Person to Contact in Case of Emergency _____

Physician Name_____ Phone Number_____

MEDICATIONS AND SUPPLEMENTS

Medications Currently Being Used (Please list all):

_____

_____

Do you currently take any supplements? (Please list all)

_____

_____

PERSONAL TRAINING GOALS

Please describe what you would like to achieve with personal training (e.g., weight loss or weight management, general health and wellness, “feel better”, sport training, or to address specific health concerns, etc.) _____

_____

_____

_____

ACTIVITY LEVEL AND FITNESS

What is your current occupation? _____

How much physical activity do you perform while on the job?
□Very Little □ Little □ Moderate □Active □Very Active

Overall Activity Level (please check one):

□ Sedentary □ Mildly Active □ Active □ Very Active

Please describe your activities and exercise: _____

_____

If you do not currently exercise, have you exercised in the past?

□ Yes □ No How much/often? _____

What type of exercise? _____

GENERAL HEALTH AND LIFESTYLE

Average or Typical Daily Meals (List items & amount)

Breakfast_____

Lunch_____

Dinner_____

Snack(s) _____

Do you drink alcohol? □ Yes □ No

If yes, how often? _____ How much? _____ Type? _____

Have you ever used any diet shakes/pills? □ Yes □ No

If yes, what was the result? _____

Have you ever been diagnosed with high blood pressure? □ Yes □ No

Have you ever been prescribed medication to control high blood pressure? □ Yes □ No

If yes, please explain: _____

_____

GENERAL HEALTH AND LIFESTYLE - continued

Do you smoke? □ Yes □ No

If no, did you ever smoke? □ Yes □ No

If yes, how long ago did you quit? _____

If yes, how much do/did you smoke? _____

If you smoke, do you want to quit? □ Yes □ No

MEDICAL HISTORY

Have you ever been diagnosed with heart problems? □ Yes □ No

Do you suffer from chest pain? □ Yes □ No

Do you ever feel faint or have spells of dizziness? □ Yes □ No

Have you ever been prescribed medication for heart problems?

□ Yes □ No If yes, please explain:_____

_____

Have you ever been diagnosed with joint or soft tissue problems? □ Yes □ No

If yes, please explain: _____

_____

Do you have any current medical problems or incompletely healed injuries? □ Yes □ No

If yes, please explain _____

_____

_____

_____

MEDICAL HISTORY - continued

Do you have any recurring problems with your:

Upper Back	□ Yes	□ No
Lower Back	□ Yes	□ No
Neck	□ Yes	□ No
Shoulders	□ Yes	□ No
Elbows	□ Yes	□ No
Wrists	□ Yes	□ No
Hips	□ Yes	□ No
Knees Ankles	□ Yes	□ No

Please explain any “yes” answers: _____

_____

What if any surgeries have you had performed and when?

_____

_____

Date of last physical exam: _____

Date of last fitness assessment: _____

I have read all of the above information and completed it to the best of my knowledge.

Signature _____ Date _____