Medical History Form

PERSONAL AND CONTACT INFORMATION

First Name_________________________ Last Name__________________________

Address ____

Phone (Home/Bus/Cell) ____

Date of Birth_____________________ Height/Weight ____________________________

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.) ____

____

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____

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 re-occurring 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 __________________