

Health History

Name _____ Date ____/____/____

Birth Date ____/____/____ Age _____

Primary Care Physician _____

Physician's Office and Phone Number _____

Emergency Contact Name _____ Phone _____

Please indicate if you have a history of any of the following:	Yes	No	Explain
1. Heart problems, chest pain, or stroke	___	___	
2. High Blood Pressure	___	___	
3. Any chronic illness or condition	___	___	
4. Difficulty with physical exercise	___	___	
5. Advice from a physician not to exercise	___	___	
6. Recent surgery (last 12 months)	___	___	
7. Pregnancy (now or within last 3 months)	___	___	
8. Breathing or lung problems	___	___	
9. Muscle, joint, or back disorder, or any previous injury that still Affects your activity level or causes you pain or discomfort	___	___	
10. Diabetes or thyroid condition	___	___	
11. Cigarette smoking habit	___	___	
12. More than 20 pounds over your ideal weight	___	___	
13. High blood cholesterol	___	___	
14. History of heart problems in immediate family	___	___	
15. Currently taking any medications	___	___	
16. Over 35 years old (men) / 40 years old (women)	___	___	
17. Hernia or any condition that may be aggravated by lifting weights	___	___	
18. Any other limiting factor, not listed above	___	___	

If you answered "yes" to any of the above Risk Factor questions, then you are strongly recommended to seek medical clearance from your physician prior to beginning a new exercise program.

Client signature _____

Date ____/____/____