Health History Form

The following information will assist us in creating a personalized program that will meet your fitness needs. Please answer all sections to the best of your ability.

- Name _____
- Birth Date _____
- Phone #_____

• Gender Male Female

• Email_____

- Emergency Contact's Name_____
- Emergency Contact's Phone #_____
- Relation to you_____

1. Do you have any chronic conditions? To ensure your safety when designing your program, please check if any of the following conditions apply to you and provide any extra information that may be relevant.

Asthma Fibromyalgia Thyroid Conditions

Chronic Fatigue Stroke Osteoporosis

Epilepsy Stress Seizures

High Blood Pressure Heart Conditions High Cholesterol Hernia(s) Lung Conditions Arthritis

Kidney Conditions Diabetes Other

Further information:

_____

_____

_____

_____

2. Please list and explain any prescription medications you are currently taking? _____

_____

3. Please list and explain any over the counter medications or supplements you are currently taking:

_____

_____

_____

4. Have you had any joint or muscle injuries and/or concerns? Please check all that apply to you and provide any further relevant information.

Neck Elbow Arms

Shoulder Wrist Legs

Upper Back Hips Chest Mid-Back Knees Foot Lower Back Ankles

Further information:

_____

5. Briefly outline any surgeries (e.g. Type, date, special considerations, etc).

_____

6. Do you smoke: yes no

If yes, how much: _____

7. Have you been active within the last 6 months? yes no

If no, how long have you been inactive for? _____

If yes please list your current activities you perform, as well as frequency, intensity and duration_____

8. Please name physical activities that you have enjoyed in the past?

_____

9. Please outline 3 fitness goals in order of priority that you would like to achieve within the next 6 months.

1. _____

2. _____

3. _____

10. What are your available training times? Day(s): _____Time(s):_____