VISIONS| OF |FITNESS

WOW CAMPER Health History Questionnaire

Client's information:

Last Name: _____ First Name: _____

Date of Birth: _____Age ___ Home Phone (____)_____Cell (____)_____

Height ____ Weight ____ E-mail address _____

Address: _____

City: _____State: _____ Zip: _____

Contact person in case of emergency:

Last name _____ First Name: _____

Relationship: _____ Phone: _____

Medical Information:
Name of Physician: _____ Phone _____

List any serious/Chronic illnesses of which you are aware:

Are you currently taking medications/supplements? Yes No

Indicate any injuries (past/present) or limitations that may affect participation in an exercise program:

Personal/Family History
Occurrence in immediate family, self, mother/father, sister/brother.

	Yes	No	You or Relative (if relative-please be specific)
High Blood pressure			
Heart Attack/Stroke			
Chest Pain			
Diabetes			
Elevated Cholesterol			
Asthma			
Obesity			

Are you a current smoker or have you recently quit smoking within the past 6 months? _____

Client's signature _____ Date: _____

All information will be kept confidential. This information will be used to evaluate your heath status and readiness to begin your exercise program. Within the legal limits of the law, this information will not be released to any other entities unless authorized by you in writing.