ChrisFIT Inc.
Health History Form

Name: _____ Date: _____ DOB: _____

Address: _____ Occupation: _____

Work: _____ Home: _____ Cell: _____ E-mail _____

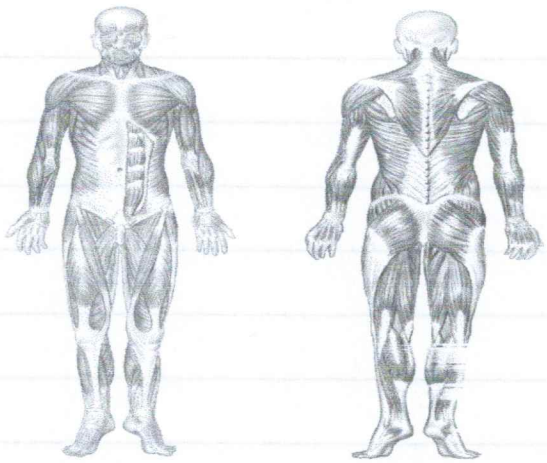
Emergency Contact/Phone: _____

Please check if you have any of the following conditions. If yes, explain below.

__ Allergies	__ Arthritis	__ Back Pain
__ Blood clots	__ Blood Pressure (high/low)	__ Bruise easily
__ Bursitis	__ Cancer	__ Constipation
__ Contagious condition	__ Diabetes	__ Diarrhea
__ Depression	__ Headaches	__ Heart attack
__ Heart problems	__ Infectious disease	__ Limited range of motion
__ Pregnant	__ Sciatic pain	__ Skin infections
__ Sleep disorders	__ Spinal problems	__ Stroke
__ Surgery	__ Varicose veins	__ Other

__ Are you currently under the care of a physician? _____
__ Are you currently taking any medications? _____
__ Do you have any other medical conditions we should be aware of? _____
__ Have you had a personal trainer before? _____
__ Do you exercise regularly? _____

Please circle any areas of pain or injury:



Notes: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have completed this health history form to the best of my ability. I understand this form does not take the place of a primary care physician. I am fully responsible for informing the trainer of any conditions that may affect my ability to exercise.

Client Signature: _____ *Date* _____