



Medical History/Client Goals 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.) _____

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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lower Back | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neck | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shoulders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Elbows | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wrists | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hips | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Knees Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 _____