

Self Administered Health Screening Personal Training

Date: _____

Name: _____

Phone (H): _____

Address: _____

Phone (W): _____

Physician's Name: _____

Physicians Phone: _____

Sex: M F Age: _____

Date of Birth M/D/Y: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

E-Mail _____

Name: _____ Relationship: _____ Phone: _____

Are you presently taking any medications? Yes No If "yes" name of medications: _____

Does your physician know you are participating in a personalized training program? _____

Describe your exercise program now: _____

Do you now, or have you had in the past year:

	Yes	No
1. History of heart problems, chest pain or stroke.	_____	_____
2. High blood pressure.	_____	_____
3. Any chronic illness or condition.	_____	_____
4. Difficulty with physical exercise.	_____	_____
5. Advice from physician not to exercise.	_____	_____
6. Recent surgery	_____	_____
7. Pregnancy (now or within last 3 months)	_____	_____
8. History of breathing or lung problems.	_____	_____
9. Muscle joint or back disorder, or injury still affecting you.	_____	_____
10. Diabetes or thyroid condition.	_____	_____
11. Cigarette smoking habit	_____	_____
12. Obesity (more than 20 percent over ideal body weight)	_____	_____
13. Increased blood cholesterol.	_____	_____
14. History of heart problems in immediate family.	_____	_____
15. Hernia, or any condition that may be aggravated by lifting weights	_____	_____

Please explain any yes answers below:

Goals: _____

