MEDICAL & HEALTH FORM

Name_____

Address _____ Email address: _____

Phone (Home/Bus/Cell) _____

Date of Birth_____ Height/Weight _____

Person to Contact in Case of Emergency _____

Physician Name_____ Phone Number_____

Last physical exam: _____ Last fitness assessment: _____

MEDICATIONS AND SUPPLEMENTS

Medications Currently Being Used (Please list all):

_____

Do you currently take any supplements? (Please list all)

_____

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? _____ Type of exercise? _____

GENERAL HEALTH AND LIFESTYLE

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: _____

Do you smoke? □ Yes □ No If no, did you ever smoke? □ Yes □ No

If yes, how long ago did you quit? _____ How much do/did you smoke? _____

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 _____

Do you have any re-occurring problems with your:

			Explain:
Upper Back	□ Yes	□ No	_____
Lower Back	□ Yes	□ No	_____
Neck	□ Yes	□ No	_____
Shoulders	□ Yes	□ No	_____
Elbows	□ Yes	□ No	_____
Wrists	□ Yes	□ No	_____
Hips	□ Yes	□ No	_____
Knees Ankles	□ Yes	□ No	_____

Have you had any surgeries performed and when?

_____

I have read all of the above information and completed it to the best of my knowledge.

Client Signature: _____ Date: _____

Instructor Name: _____