

HEALTH HISTORY

In order to assist you in the development of a rewarding physical fitness program, your honest and accurate responses are appreciated.

Answer each question by printing the necessary information. Your answers will be kept confidential. **Please print legibly.**

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Facebook: _____

Height: _____ Weight: _____ Age: _____

Birthday: _____

Employer: _____ Occupation: _____

Physician: _____ Telephone: _____

Contact in case of emergency:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

	Yes	No	Explain
High Blood Pressure			
Coronary Artery Disease, any Heart Problems			
High Blood Cholesterol			
Diabetes (Type 1 or 2)			
Cigarette or any other Smoking Habit			
Chest Pains			

	Yes	No	Explain
Shortness of Breath, Asthma			
Lung Problems or Disease			
Spells of Dizziness or Fainting			
Seizures or convulsions			
Numbness or Tingling			
Liver Disease			
Hypo/Hyper Glycemia			
Thyroid Disease			
Kidney Disease			
Allergies			
Neurological, Headaches, Epilepsy			
Cancer			
Digestive System			
Eyes or Ears			
Cosmetic/Reconstructive			
Stroke			
Back Problems			
Neck Problems			
Knee Problems			
Shoulder Problems			
Foot, Ankle, Hip, Elbow, Wrist, Hand			
Joints - popping, clicking, grinding, swelling, gout			
Muscular Disorder			
Pregnant, Currently or Planning			

	Yes	No	Explain
Osteoarthritis, rheumatoid arthritis, etc.			
Medications			
Recent Illness, Infections, or Injury, or surgery/current care at a physician, chiropractor, or other person providing health care services			
Date of last Physical / Lab Work			

HIV Tested (Optional) _____

Any other conditions you feel will be helpful in your training to avoid injuries:

Print Name: _____

Signature: _____ Date: _____