

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

Telephone: H \_\_\_\_\_ AGE: \_\_\_\_\_

Telephone: C \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female: \_\_\_\_\_

Telephone: W \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Email: \_\_\_\_\_ Fax \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Describe present exercise program. \_\_\_\_\_

What are your goals. \_\_\_\_\_

Time commitment to training? \_\_\_\_\_

Do you now or have you had in the past:	YES	NO
1. Heart problems, chest pain or stroke	_____	_____
2. Increased blood pressure	_____	_____
3. Any chronic illness or condition	_____	_____
4. Difficulty with physical exercise	_____	_____
5. Recent surgery last 12 months	_____	_____
6. Pregnancy (now or past 6 months)	_____	_____
7. Breathing or lung problems	_____	_____
8. Muscle joint or back disorders	_____	_____
9. Any pain or discomfort not diagnosed as injury	_____	_____
10. Diabetes or thyroid condition	_____	_____
11. History of heart trouble in family	_____	_____
12. Hernia now or in the past	_____	_____
13. Cigarette smoking habit	_____	_____
14. Alcohol consumption, more than 3 drinks per week	_____	_____

Comments regarding yes to answers above or anything significant to your present health \_\_\_\_\_

Are you currently on any medications or drugs. \_\_\_\_\_

\_\_\_\_\_  
DATE \_\_\_\_\_

CLIENT SIGNATURE

\_\_\_\_\_  
DATE \_\_\_\_\_

TRAINER SIGNATURE