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:_____

_____

_____

_____

****All information given is confidential.**