Health History Form

For the following questions, please be as accurate and honest as possible to strengthen your outcome in the program.

Medical History and Information
Are you under the care of a physician, chiropractor, or any other health care provider for any reason? _____
If yes, list reason: _____
Are you aware of any disease or disorder that would complicate your participation in a testing or exercise program?
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?
Are you taking medications? If yes, please indicate the type of medication, dosage, frequency and reason(s) for taking it:
Have you had any surgeries in the past 12 months? If yes, please list: _____
Please list any allergies: _____
Has your doctor ever said your blood pressure was too high/low? _____
Do you smoke Tobacco? _____
Are you unaccustomed to vigorous exercise?

Skeletal Injuries

Back: _____

Head: _____

Neck: _____

Lower Extremities (R, L): _____

Upper Extremities (R, L): _____

Other: _____

Please describe any special considerations or how your injury currently affects your ability to function: _____

Please talk with your doctor by phone or in person before you start any new training program or have a fitness assessment. Tell your doctor about your health questionnaire and which questions you answered yes.

Signature of Client

Date

Printed name of Client

Signature of Parent/Guardian if under the age of 18

Date

Printed name of Parent/Guardian

Signature of Trainer

Date