

## TAILOR'D FITNESS Health and Medical History

Name \_\_\_\_\_

Date \_\_\_\_\_

Date of birth \_\_\_\_\_

Emergency contact:

Name / Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other change in their physical activity levels.

Yes    No

- |     |     |  |
|-----|-----|--|
| ___ | ___ | 1. Are you over age 55 and/or not accustomed to vigorous exercise?   |
| ___ | ___ | 2. Have you ever been diagnosed with Type I or Type II Diabetes?   |
| ___ | ___ | 3. Do you have any reason to suspect that you might now pregnant, or have you been pregnant within the last 3 months?  |
| ___ | ___ | 4. Have you had any major or minor surgery in the past 3 months?   |
| ___ | ___ | 5. Have you been hospitalized in the last 2 years? If so, when and for what reason?<br>_____   |
| ___ | ___ | 6. Are you currently, or have you in the past, ever seen a chiropractor or physical therapist for any condition? If yes, when and for what condition?<br>_____ |
| ___ | ___ | 7. Do you ever experience unexpected shortness of breath, or labored breathing, with or without pain? If yes, describe under what conditions.<br>_____         |
| ___ | ___ | 8. Do you currently, or have you ever, experienced unexplained heart palpitations or been diagnosed with a heart murmur or irregular heartbeat?                |

Yes No

\_\_\_ \_\_\_ 9. Have you ever been diagnosed with high blood pressure? If yes, when? \_\_\_\_\_

\_\_\_ \_\_\_ 10. Do you know what your blood pressure normally is? If yes, please state \_\_\_\_\_ / \_\_\_\_\_

\_\_\_ \_\_\_ 11. Do you currently smoke? If yes, how many cigarettes per day? \_\_\_\_\_

\_\_\_ \_\_\_ 12. Did you ever smoke? If yes, how long ago did you quit?

\_\_\_ \_\_\_ 13. Is there any history of heart disease (prior to age 55) in your immediate family? If yes, explain.

\_\_\_\_\_

\_\_\_ \_\_\_ 14. Do you know your cholesterol levels? If so, please state: \_\_\_\_\_

\_\_\_ \_\_\_ 15. Do you receive regular annual physical exams from your primary care physician? Date of last exam:

\_\_\_\_\_

\_\_\_ \_\_\_ 16. Do you have any pain, discomfort, or known current or previous injury to any of the following areas:

\_\_\_ \_\_\_ Right or left knee (circle as appropriate)

\_\_\_ \_\_\_ Right or left shoulder (circle as appropriate)

\_\_\_ \_\_\_ Right or left elbow (circle as appropriate)

\_\_\_ \_\_\_ Right or left elbow (circle as appropriate)

\_\_\_ \_\_\_ Right or left wrist (circle as appropriate)

\_\_\_ \_\_\_ Right or left ankle (circle as appropriate)

\_\_\_ \_\_\_ Right or left hip (circle as appropriate)

\_\_\_ \_\_\_ Back or neck (circle as appropriate)

If you checked “Yes” to any of the above, please explain the nature of your pain and/or injury. Do certain activities or conditions aggravate the pain and/or injury?

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Are there any other health/medical/injury conditions that your trainer should be aware of?

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Please list any prescription medications or over-the-counter medications or supplements you currently take:

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I, \_\_\_\_\_, certify that I understand the foregoing questions and my answers are true and complete. I also understand that if this information changes in any way in the future, it is my responsibility to notify my personal trainer, and that I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Before beginning a new fitness program or other significant change in your physical activity levels, you are advised to consult with your physician or primary health care provider. Only a physician or qualified health care provider is able to diagnose and prescribe treatment for specific health conditions.

I acknowledge that I have read the foregoing statements and fully understand the content thereof, and that if I choose not to consult with my physician or primary health care provider, I do so at my own risk.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Please print name \_\_\_\_\_

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Parent or legal guardian (if participant is under age eighteen) \_\_\_\_\_ Date \_\_\_\_\_