INTAKE AND PAST MEDICAL HISTORY FORM

Name ______ Date of Birth ______

Address ______

Home Tel ______ Cell ______ Email ______

Emergency Contact ______ Telephone ______

Do you have any of the following:

Chest Pain	___ Yes ___ No	Coronary Heart Disease	___ Yes ___ No
Irregular Heartbeats	___ Yes ___ No	High Blood Pressure	___ Yes ___ No
Respiratory Problems	___ Yes ___ No	High Cholesterol	___ Yes ___ No
Shortness of Breath	___ Yes ___ No	Dizziness/loss of consciousness	___ Yes ___ No
Chronic Cough	___ Yes ___ No	Diabetes	___ Yes ___ No
Obesity	___ Yes ___ No	Arthritis	___ Yes ___ No
Bone, joint, or muscle injury	___ Yes ___ No	Low Back Pain	___ Yes ___ No
Seizures or Convulsions	___ Yes ___ No	Severe Headaches	___ Yes ___ No

Surgery (s)? - What, when, why, how many?

______

______

Are you on any medications? (Please list)

______

______

Do you smoke? _____ Yes _____ No

Do you have any physical problems that are of concern to you?

______

______

What does your physician recommend?

______

______

What are your goals for this exercise program?

______

______

*CONSULT YOUR PHYSICIAN BEFORE BEGINNING ANY EXERCISE PROGRAM