Fitness Health Questionaire

All information on this form will be treated as strictly confidential. Please fill out the form completely and accurately. This information is essential for contact and emergency information and history.

Name:_____ Date of Birth____/____/_____

Age:_____ Address:_____

Phone: (Home) _____ (Cell)_____

Email Address:_____

Emergency Contact:_____ Phone #:_____

Physician Name:_____ Phone#:_____

Yes/NO

- Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?
  _____
- Do you frequently have pains in your chest when you perform physical activity?
  _____
- Do you lose your balance due to dizziness or do you ever lose consciousness?
  _____
- Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program?
  Circle: (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems).
  Other:_____
- Do you take medication on a regular basis? If Yes, does how does your ability to exercise?
  _____
- On a scale of 1-10 how would you rate your fitness level (1=Worst 10=Best)
  Elaborate:_____
- What is your fitness goals:
  _____
  _____
  _____
  _____