PERSONAL INFORMATION

Contact details

Name _____ **Age** _____ **Sex** ☐ Female ☐ Male

Address _____

Day Phone _____ **Evening Phone** _____ **Email** _____

Emergency Contact _____ **Phone** _____ **D.O.B.** _____

PHYSICAL ACTIVITY AND MEDICAL QUESTIONNAIRE

1. Has your doctor ever said that you have a heart condition and recommended only medically supervised activity? ☐ Yes ☐ No

2. Do you have any chest pain brought out only by physical activity? ☐ Yes ☐ No

3. Do you tend to lose consciousness or fall over as a result of dizziness? ☐ Yes ☐ No

4. Do you have a joint or bone condition that could be aggravated by physical activity? ☐ Yes ☐ No

5. Do you have any medical condition that we should be aware of, before starting any Personal Training program involving strength and resistance training exercises? ☐ Yes ☐ No

6. Date of the last Physical Exam? _____ Name of Primary Care Physician _____

7. Are you currently being treated for any injury? ☐ Yes ☐ No

If Yes, explain: _____

DO YOU HAVE ANY OF THE FOLLOWING?

a) Heart condition? ☐ Yes ☐ No

b) Diabetes? ☐ Yes ☐ No

c) Uncontrolled Asthma? ☐ Yes ☐ No

d) Shortness of Breath? ☐ Yes ☐ No

e) Arthritis? ☐ Yes ☐ No

f) Rheumatism? ☐ Yes ☐ No

g) Hernia? ☐ Yes ☐ No

h) Recent Surgery (within the last 5 years)? ☐ Yes ☐ No

i) High/Low Blood Pressure? ☐ Yes ☐ No

j) Knee/Hip Problems? ☐ Yes ☐ No

k) Back or neck discomfort? ☐ Yes ☐ No

CERTIFICATION

I certify that the above statements are true and correct. I understand that a doctor's note may be required, if necessary. If a note is requested, we cannot proceed with any exercise program until such a note has been provided by you and signed by your doctor.

Signature _____ **Date** _____

Electronic signature: typing your name does not by itself establish legal validity.