Personal Training Client Health History Form

Please answer each question by printing the necessary information. Your answers will be kept confidential.

Client Information and Release Form

Name _____ Birth Date _____ Gender _____

Address _____

City _____ State _____ Zip _____

Phone Number(s) Home_____ Work _____ Cell _____

E-mail _____

Employer _____ Occupation_____

In case of emergency, please notify:

Name_____ Relationship _____

Address _____

City _____ State _____ Zip _____

Phone Number(s) _____ Home _____ Work _____ Cell

General Medical History & Information

Are you under the care of a physician, chiropractor, or other health care professional 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 any medications? If yes please indicate the type of medication, dosage, frequency and reason(s) for taking it. _____

Please list any allergies_____

Has your doctor ever said your blood pressure was too high? _____

Are you over age 65? _____ Are **you unaccustomed to vigorous exercise?** _____

Is there any reason not mentioned here why you should not follow a regular exercise program?
If so, please explain _____

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

Head / Neck _____

Upper Back _____

Shoulder / Clavicle _____

Arm / Elbow _____

Wrist / Hand _____

Lower Back _____

Hip / Pelvis _____

Thigh / Knee _____

Lower Leg / Ankle / Foot

Additional Information:

Have you recently experienced any chest pain associated with either exercise or stress?
If so, please explain _____

Do you have a family history of any of the following conditions?

Heart Disease _____ Heart Attack _____ Hypertension _____ Gout _____

Abnormal EKG _____ Asthma _____ High Cholesterol _____ Angina _____

Diabetes _____ Other heart conditions _____

Do you have a family history of cardiovascular disease? If so, how many occurrences and what approximate ages? _____

Are you a smoker? If so, what is your smoking frequency? _____

Are you on any specific food / nutritional plan at this time? _____

Do you take dietary supplements? If yes, please list _____

_____

How many beverages do you consume per day that contains caffeine? _____

Do you experience any frequent weight fluctuations? _____

Have you experienced a recent weight gain or loss? _____

If yes, list change _____Over how long? _____

Your answers to these questions will be discussed with you prior to your session. Thank You.

Please take a moment to carefully read the above information and sign where indicated.

Additional Information:

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

Signature_____ Date _____

Consent for minors is required prior to first session.

Signature of Guardian_____ Date _____

Printed name of Guardian _____

Phone number the Guardian can be reached in case of emergency _____

Client Profile Questionnaire

Current Exercise Information

Please explain your current exercise regimen including all strength training, cardiovascular training or other sporting activities that you perform.

Day of the Week / Activity / Length of Time

Body Type / Activity Level / Goal Information

What are your goals? (Check those that apply)

Body Fat Loss Balance Strength Production Increase Flexibility General Health Maintenance

How active are you and/or what is your exercise lifestyle like?

Sedentary Moderate Exercise Competitive Exercise Pre/Post Rehab

Does your daily life require you to be.....

Sedentary Somewhat Active Active Very Active

Please answer yes or no to the following questions:

Is it hard for you to gain weight?
Can you eat a lot and still not gain weight?
Do you gain or lose weight according to your fluctuations in activity and food consumption?
Is it hard for you to lose weight?
Do you gain weight if you're not careful about food intake?

Current Nutritional Consumption

Please list the foods, beverages, supplements etc that you take on the average day.

Time / Qty / Food-Beverage-Supplement

Short / Long-Term Goals:

Please describe your typical daily activities:

Please take a moment to carefully read the following information and sign where indicated.

Thank-you for completing this health history questionnaire, all information will be kept confidential and only referenced to develop your personal fitness program.

Signature_____ **Date** _____

Studio P Oakland
studiopoakland@gmail.com
studiopoakland.com