

Name \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_

Sex F M Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Prescriptions or Medications? \_\_\_\_\_

Did you consult your physician before beginning this exercise program? \_\_\_\_\_

Describe your current exercise program. \_\_\_\_\_

*Do you now, or have you in the past:*

**Yes      No**

1. History of heart problems, chest pain or stroke. \_\_\_\_\_

\* **2. Increased blood pressure. If yes, medication?** \_\_\_\_\_

3. Any chronic illness or condition? \_\_\_\_\_

4. Difficulty with physical exercise? \_\_\_\_\_

5. Advice from a physician not to exercise? \_\_\_\_\_

6. Recent surgery (last 12 months)? \_\_\_\_\_

7. Pregnancy?(now or last 3 months)? \_\_\_\_\_

8. History of breathing or lung problems? \_\_\_\_\_

9. Muscle, joint back disorder or any previous injury still affecting you? \_\_\_\_\_

\* **10. Diabetes or thyroid condition?** \_\_\_\_\_

\* **11. Cigarette smoking habit?** \_\_\_\_\_

12. Obesity (20% or more over ideal body weight)? \_\_\_\_\_

\* **13. Increased blood cholesterol level?** \_\_\_\_\_

\* **14. History of heart problems in immediate family?** \_\_\_\_\_

15. Hernia, or any condition that may be aggravated? \_\_\_\_\_

16. Please explain any "Yes" answers on the back

\* "Yes" to one or more of these questions increases risk of injury during exercise.