Fit By Jan
Health History Form

Name: _____ Date:_____
Address: _____
Phone: (day)_____ (evening)_____
Age: _____ Birth date: _____

Are you currently taking any Medication? Yes ___ No___
Type_____ Purpose_____
Type_____ Purpose_____
Type_____ Purpose_____

Could any of these medications cause a reaction while exercising? Yes___ No____

Do you have or have you ever had any of the following conditions?

Condition			Description of Condition
Heart Attack	Y___	N___	_____
Stroke	Y___	N___	_____
Chest Pain	Y___	N___	_____
High Blood Pressure	Y___	N___	_____
Cancer	Y___	N___	_____
High Cholesterol	Y___	N___	_____
Diabetes	Y___	N___	_____
Arthritis	Y___	N___	_____
Thyroid Problems	Y___	N___	_____
Hernia	Y___	N___	_____
Anemia	Y___	N___	_____
Obesity	Y___	N___	_____
Breathing or Lung Problems	Y___	N___	_____
Other	Y___	N___	_____

Have you ever been injured in any of the following areas? If yes, please describe:

Body Area			Date and Description of Injury
Neck	Y___	N___	_____
Shoulders	Y___	N___	_____
Arms/Hands	Y___	N___	_____
Back	Y___	N___	_____
Knees	Y___	N___	_____
Feet	Y___	N___	_____
Hips	Y___	N___	_____
Other	Y___	N___	_____

Are you currently under the care of a physician for any reason? Y___ N___
If yes, please explain:_____

PAGE 2

Do you know of any physical condition you have that could be aggravated by exercise or exertion? Y___ N___ If yes, please explain: _____
_____

Do you smoke? Y___ N___ If yes, how much_____

How much water do you consume in a day? _____

How many alcoholic beverages do you consume in a week? _____

Are you currently involved in an exercise program? Y___ N___
If so, please describe: _____
_____

Do you start an exercise program and then find yourself unable to stick with it?
Y___ N___

What recreational sports or hobbies do you engage in? _____
_____

Women: Are you currently pregnant: Y___ N___

What are your goals for this workout program?
Goal: _____
Goal: _____
Goal: _____

Is there any other health information you would like to relay regarding your physical condition? Y___ N___
If yes, please explain: _____
_____

Emergency Contact: _____Relationship_____
Phone number: (day)_____(evening)_____

Primary Care Physician: _____ Phone_____

I acknowledge the above information contained on this Health History Form to be accurate. If there are any changes to the above information, I will address these with my trainer.

Print Name: _____ Date:_____

Signature: _____