Personal Training Client Information Form

Name:	Home Phone:
Birthdate:	Cell Phone:
Address:	Emergency Contact:
Postal Code:	Emergency Contact Phone:
Email:	Medical Doctor:
Occupation:	Stress Level: High Med Low
Hours of work per week:	

Medical History

Describe your current state of health:

Date of last complete medical:

Have you sustained any injuries? (fractures, motor vehicle accidents, sport injury – any injury that required medical treatment).

Surgery or operations? (please list)

Is there a family history of any medical illness or condition?

Are you using any medication or supplements? (current or in the last eight months)

Do you have neck problems?

Nature: Limitations:

Do you smoke? Average alcohol intake:

How often do you drink coffee/tea/soft drinks? Average water intake: Average # of hours of sleep:

Current nutrition habits: (typical breakfast /lunch/dinner/snacks:

Is your work sedentary? (office work or physical)

Describe your current fitness level:

GOALS:

Fitness/Health goals**:**

Client /Trainer expectations:

STAFF NOTES:

Blood Pressure: **Resting Heart Rate:** **Height:** **Weight:**

Health History

Check the following conditions that apply to you, Past (P) and Current (C). Please add comments to clarify the condition on lines provided or on the back of the form if needed.

Muscular-skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/Fractured bones
- ☐ Sprains/strains
- ☐ Dislocation/separation
- ☐ Back/hip pain
- ☐ Knee/ankle/foot pain
- ☐ Shoulder/neck pain
- ☐ Elbow/wrist/hand pain
- ☐ Chest/rib pain
- ☐ Jaw pain/TMJ
- ☐ Gait/Walking problems
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease
- ☐ Other

Circulatory /Respiratory

- ☐ Dizziness
- ☐ Loss of consciousness/fainting
- ☐ Shortness of breath
- ☐ Phlebitis
- ☐ Cold hands/feet
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Cholesterol
- ☐ Other

Digestive

- ☐ Diabetes
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Other

Nervous System

- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral palsy
- ☐ Post/Polio syndrome
- ☐ Epilepsy
- ☐ Chronic fatigue syndrome
- ☐ Fibromyalgia
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Parkinson's disease
- ☐ Spinal cord injury
- ☐ Connective tissue disorder
- ☐ Numbness/tingling
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers

Reproductive System

- ☐ Pregnancy – current – previous – complications
- ☐ Menopause
- ☐ Pelvic inflammatory disease
- ☐ Endometriosis
- ☐ Hysterectomy

Other Health History

- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use
- ☐ Thyroid
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Cancer – treatment type
- ☐ Infectious disease (please list)
- ☐ Other congenital or acquired disability (please list)

Please list any additional comments regarding your health and well-being:

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Complete Body Health of any changes in my health status.

Client Signature: Date: