



PERSONAL FITNESS TRAINING
by Birgitt Haderlein
Health Screening

NAME: _____ Date: _____

Sex: Male Female

Physician's Name: _____

Physicians Phone: _____

Person to Contact in Case of Emergency:

Name _____ Relationship _____ Phone _____

Are you taking any medications or drugs? Yes No What? _____

Does your physician know you are participating in this exercise program? Yes No

Describe your exercise program now: _____

Table with 3 columns: Question, Yes, No. Contains 16 health-related screening questions.

Comments: _____

Client Signature: _____