



ToFitYou

Where the mind goes
the energy flows

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: _____

Do you now, or have you had in the past:	Yes	No
1. History of heart problems, chest pain or stroke?	_____	_____
2. Increased blood pressure?	_____	_____
3. Any chronic illness or condition?	_____	_____
4. Difficulty with physical exercise?	_____	_____
5. Advice from physician not to exercise?	_____	_____
6. Recent surgery (last 12 months)?	_____	_____
7. Pregnancy (now or within last 3 months)?	_____	_____
8. History of breathing or lung problems?	_____	_____
9. Muscle, joint, or back disorder, or any previous injury still affecting you?	_____	_____
10. Diabetes or thyroid condition?	_____	_____
11. Cigarette smoking habit?	_____	_____
12. Obesity (more than 20 percent over ideal body weight)?	_____	_____
13. Increased blood cholesterol?	_____	_____
14. History of heart problems in immediate family?	_____	_____
15. Hernia, or any condition that maybe aggravated by lifting weights?	_____	_____
16. Please explain any yes answers below.		

Comments: _____

Client Signature: _____