F.I.T.

Focused
Individualized
Technique Based

PERSONAL TRAINING

MEDICAL HISTORY:

Name ____________________________________ Date ____________ GP's Name _____________________________

Address __________________________________ City ___________________________ Postal Code _____________

Phone # __________________________________ Email ____

Age __________________ Weight _______________ Height ________________ Sex (optional) ________________

Person to contact in case of emergency ____

Relationship ____ Phone # _______________________________________

Describe your current exercise habits / programme:

Type ____

Frequency ____

Duration ____

Intensity ____

What is you occupation? ____

Describe your day?

A.M.____
____
____
____

Work ____
____
____
____

Midday____
____
____
____

P.M.____
____
____
____

What are your recreational interests/hobbies?

____
____
____
____

Physically, what are your barriers?

____
____
____
____

Have you experienced any of the following especially associated with physical activity, eating a large meal, emotional distress, or exposure to cold? (please be specific)

YES **NO** 1. Discomfort: Pressure, tingling, pain, heaviness, burning, numbness in chest, jaw, neck, or arms?
____

YES **NO** 2. Lightheaded, dizzy, or fainting?
____

YES **NO** 3. Shortness of breath?
____

YES **NO** 4. Rapid heartbeats or palpitations?
____

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

YES **NO** 1. Cardiovascular Disease and/or Hypertension?
____

YES **NO** 2. Pulmonary Disease – asthma, emphysema, and/or bronchitis?
____

YES **NO** 3. Diabetes (**Type I** or **Type II**)?
____

YES **NO** 4. Peripheral Vascular Disease?
____

YES **NO** 5. Cancer?
Type: ____

When had Surgery? ____

Lymph nodes removed? (how many)? ____

Chemo? Radiation? Treatment? ____

Lymphedema? ____

YES **NO** 6. Osteoporosis? / Osteopenia?
____

YES **NO** 7. Abnormal Heart Sounds?

____

YES **NO** 8. Oedema?

____

YES **NO** 9. Recently ill, hospitalized, or had surgery? Explain: ______________________________________

____

____

YES **NO** 10. Arthritis?

____

YES **NO** 11. Joint Swelling?

____

YES **NO** 12. Any Orthopedic problem(s) of any kind?

____

____

YES **NO** 13. Medications?

____

____

YES **NO** 14. Allergies? (Environmental, Drug)

____

____

YES **NO** 15. Tobacco? Caffeine?

____

YES **NO** 16. Have you been told by a physician or other health care provider that you are overweight/obese?

____

YES **NO** 17. Do you have now or have you ever had a hernia or any other condition that may be aggravated by lifting weights?

____

YES **NO** 18. Eating disorders (past or present)?

____

YES **NO** 19. Emotional Disorders?

____

Please specify if you have a <u>family history</u> of serious illness, or conditions such as heart disease, cancer, lung problems, diabetes, hypertension, or cholesterol?

____
____
____
____

Are there any other conditions or heath matters needing discussion prior to your participation in any physical activities?

____
____
____

By signing and dating below I do hereby acknowledge that I am responsible for the full disclosure of any information that is requested on this form and the information I have provided in this Medical History Questionnaire is true and complete to the best of my knowledge. I have been instructed to update this form as changes in my health status/medications occur. All information is confidential and will not be shared or discussed with others without your consent.

____

____ _______________________
Signature of Participant Date

____ _______________________
Signature of Personal Trainer Date

Any health conditions that require a physician/therapist's clearance to participate, must be obtained, completed, and signed prior to beginning any fitness training. (Please Initial __________)

....

Please see the back page to complete your Health and Fitness Goals

Give these goals you FULL ATTENTION!

These goals will be related to areas of your life, family, recreation, health and fitness.

These goals will be used as guidelines to create your programme and new life habits.

Please note: These are YOUR goals! Be specific. Be Honest. Be Realistic.

What are your health and fitness goals?

(1) ____

____

(2) ____

____

(3) ____

____

(4) ____

____

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