



Helene's Health & Fitness

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585-509-1190

Today's Date: _____

HEALTH SCREEN, MEDICAL PROFILE AND EXERCISE HISTORY FORM

In order to help design a personal health program appropriate to your needs, we must obtain necessary information about your current state of health. For most people, physical activity does not pose a problem, though for some individuals, certain types of activity may be inappropriate or dangerous. In some cases, medical clearance and/or clarification from a physician may be needed before an exercise program can be designed.

Name: _____ Phone [H]: _____
& _____ Phone [W]: _____
Address _____ Birth Date: _____
M/F: _____ Age: _____ Ht: _____ Wt: _____

EMERGENCY CONTACT [Please list a relative or close friend we may contact in case of emergency]

Name: _____ Phone: _____
Relationship to you: _____
Dr's Name: _____ Phone : _____

GENERAL HEALTH INFORMATION

Do you have high blood pressure? Yes No
If yes, are you currently on medication for high blood pressure: Yes No
Have you had high blood pressure in the past? Yes No

Do you smoke? Yes No
Are you a former smoker? Yes No
If yes, how long were you a smoker? _____ Date you quit: _____

Is there a history of heart or circulatory disease in your family? Yes No
If yes, please give details: _____

Have you ever been told by a doctor that you have heart/circulatory problems, high cholesterol or triglyceride levels? Yes No

If yes, please indicate specific history & give dates below:

Heart attack	Date: _____	Cardiac pacemaker:	Date: _____
Heart bypass surgery	Date: _____	Angina	Date: _____
Balloon angioplasty	Date: _____	Irregular heart rhythms	Date: _____
Stroke	Date: _____	Rheumatic heart disease	Date: _____
High triglycerides	Date: _____	Heart murmurs	Date: _____
High cholesterol	Date: _____	Other	Date: _____

If Other, please describe: _____

GENERAL HEALTH INFORMATION [CON'T]

Have you had any injuries, surgeries or illnesses that would limit your ability to exercise? Yes No

If yes, please describe: _____

Have you ever required physical therapy or chiropractic attention? Yes No

Are you currently involved in physical therapy, chiropractic or alternative therapies? Yes No

Have you ever experienced any of the following [please circle all that apply]:

- | | | |
|-------------------|-----------------|---------------------|
| Anemia | Asthma | Diabetes |
| Pulmonary disease | Kidney disease | Cancer |
| Arthritis | Fainting spells | Back/Leg pain |
| Poor vision | Poor hearing | Hands/Feet swelling |
| Knee pain | Shoulder pain | Ankle pain |
| Osteoporosis | Fibromyalgia | |

Please list any medications you are currently taking:

Name of Drug	Reason for taking
_____	_____
_____	_____
_____	_____

EXERCISE HISTORY AND GOALS

Is there any medical reason, not mentioned here, that would prevent or limit your ability to engage in physical activity? Yes No

Are you presently following an exercise program? Yes No

If so, please briefly describe the program:

Briefly describe any goals you have in mind for your training program for the next three months:

I ATTEST THAT THE INFORMATION I HAVE GIVEN HERE IS COMPLETE AND CORRECT, AND THAT TO THE BEST OF MY KNOWLEDGE I AM PHYSICALLY ABLE TO PARTICIPATE IN AN EXERCISE PROGRAM.

Client Signature

Date