



# Medical History/Client Goals Form

## PERSONAL AND CONTACT INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

Phone (Home/Bus/Cell) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height/Weight \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

## MEDICATIONS AND SUPPLEMENTS

Medications Currently Being Used (Please list all):

\_\_\_\_\_  
\_\_\_\_\_

Do you currently take any supplements? (Please list all)

\_\_\_\_\_  
\_\_\_\_\_

## PERSONAL TRAINING GOALS

Please describe what you would like to achieve with personal training (e.g., weight loss or weight management, general health and wellness, “feel better”, sport training, or to address specific health concerns, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ACTIVITY LEVEL AND FITNESS**

What is your current occupation? \_\_\_\_\_

How much physical activity do you perform while on the job?

- Very Little    Little    Moderate    Active    Very Active

Overall Activity Level (please check one):

- Sedentary    Mildly Active    Active    Very Active

Please describe your activities and exercise: \_\_\_\_\_

If you do not currently exercise, have you exercised in the past?

- Yes    No   How much/often? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

**GENERAL HEALTH AND LIFESTYLE**

Average or Typical Daily Meals (List items & amount)

**Breakfast** \_\_\_\_\_

**Lunch** \_\_\_\_\_

**Dinner** \_\_\_\_\_

**Snack(s)** \_\_\_\_\_

Do you drink alcohol?    Yes    No

If yes, how often? \_\_\_\_\_ How much? \_\_\_\_\_ Type? \_\_\_\_\_

Have you ever used any diet shakes/pills?    Yes    No

If yes, what was the result? \_\_\_\_\_

Have you ever been diagnosed with high blood pressure?    Yes    No

Have you ever been prescribed medication to control high blood pressure?    Yes    No

If yes, please explain: \_\_\_\_\_

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**GENERAL HEALTH AND LIFESTYLE - continued**

Do you smoke?                       Yes               No

If no, did you ever smoke?       Yes               No

If yes, how long ago did you quit? \_\_\_\_\_

If yes, how much do/did you smoke? \_\_\_\_\_

If you smoke, do you want to quit?       Yes               No

**MEDICAL HISTORY**

Have you ever been diagnosed with heart problems?       Yes  No

Do you suffer from chest pain?       Yes               No

Do you ever feel faint or have spells of dizziness?       Yes               No

Have you ever been prescribed medication for heart problems?

Yes  No

If yes, please explain: \_\_\_\_\_

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Have you ever been diagnosed with joint or soft tissue problems?       Yes               No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you have any current medical problems or incompletely healed injuries?       Yes  No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY - continued**

Do you have any re-occurring problems with your:

- |              |                              |                             |
|--------------|------------------------------|-----------------------------|
| Upper Back   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lower Back   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neck         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shoulders    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Elbows       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wrists       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hips         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Knees Ankles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain any "yes" answers: \_\_\_\_\_

\_\_\_\_\_

What if any surgeries have you had performed and when?

\_\_\_\_\_

\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Date of last fitness assessment: \_\_\_\_\_

I have read all of the above information and completed it to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_