PEAK
RESULTS FITNESS
Flagstaff, AZ ▪ PeakResultsFlagstaff.com ▪ 928.255.0339

Health and Medical History

Name:_____ Date of Birth:____/____/____ Today's Date:____/____/____

Street Address:_____ Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone #:(_____)_____-_____ Work Phone #:(_____)_____-_____ Cell Phone #:(_____)_____-_____

Email Address:_____

Emergency Contact:_____ Relationship:_____

Home Phone #:(_____)_____-_____ Work Phone #:(_____)_____-_____ Cell Phone #:(_____)_____-_____

Email Address:_____

What are your top three fitness goals?:

1._____

2._____

3._____

Physical activity should not pose any problem or hazard to the majority of people. The following questions are designed to identify the small number of adults for whom physical activity might be inappropriate or those who should seek medical advice prior to initiating a fitness program or other change in their physical activity levels. Please mark either Yes or No.

Yes No

___ ___ 1. Are you over age 55 and/or not accustomed to vigorous exercise?

___ ___ 2. Have you ever been diagnosed with Type I or Type II Diabetes?

___ ___ 3. Do you have any reason to suspect that you might now be pregnant, or have you been pregnant within the last 3 months?

___ ___ 4. Have you had any major or minor surgery in the past 3 months?

___ ___ 5. Have you been hospitalized in the last 2 years? If so, when and for what reason?:

_____

Yes No

___ ___ 6. Are you currently, or have you in the past, ever seen a chiropractor or physical therapist for any condition? If yes, when and for what condition?:

_____

___ ___ 7. Do you ever experience unexpected shortness of breath, or labored breathing, with or without pain? If yes, describe under what conditions:

_____

___ ___ 8. Do you currently, or have you ever, experienced unexplained heart palpitations or been diagnosed with a heart murmur or irregular heartbeat?

___ ___ 9. Have you ever been diagnosed with high blood pressure? If yes, when?:_____

___ ___ 10. Do you know what your blood pressure normally is? If yes, please state:_____ /_____

___ ___ 11. Do you currently smoke? If yes, how many cigarettes per day?:_____

___ ___ 12. Did you ever smoke? If yes, how long ago did you quit?:_____

___ ___ 13. Is there any history of heart disease (prior to age 55) in your immediate family? If yes, explain:

_____

___ ___ 14. Do you know your cholesterol levels? If so, please state:

HDL:_____ LDL:_____ Triglycerides:_____ Total Cholesterol:_____

___ ___ 15. Do you receive regular annual physical exams from your primary care physician?

Date of last exam: ____/____/____

___ ___ 16. Do you have any pain, discomfort, or known current or previous injury to any of the following areas:

Yes	No		Yes	No	
___	___	Right or left knee (circle as appropriate)	___	___	Right or left shoulder (circle as appropriate)
___	___	Right or left elbow (circle as appropriate)	___	___	Right or left elbow (circle as appropriate)
___	___	Right or left wrist (circle as appropriate)	___	___	Right or left ankle (circle as appropriate)
___	___	Right or left hip (circle as appropriate)	___	___	Back or neck (circle as appropriate)

If you checked "Yes" to any of the above, please explain the nature of your pain and/or injury. Do certain activities or conditions aggravate the pain and/or injury?:

_____

_____

_____

_____

Are there any other health/medical/injury conditions that your trainer should be aware of?:

_____

_____

_____

_____

Please list any prescription medications or over-the-counter medications or supplements you currently take:

Medication:_____Reason:_____

Medication:_____Reason:_____

Medication:_____Reason:_____

Medication:_____Reason:_____

I, _____, certify that I understand the foregoing questions and my answers are true and complete. I also understand that if this information changes in any way in the future, it is my responsibility to notify my personal trainer, and that I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Before beginning a new fitness program or other significant change in your physical activity levels, you are advised to consult with your physician or primary health care provider. Only a physician or qualified health care provider is able to diagnose and prescribe treatment for specific health conditions. I acknowledge that I have read the foregoing statements and fully understand the content thereof, and that if I choose not to consult with my physician or primary health care provider, I do so at my own risk.

_____ _____

Signature Date Print Name

_____ _____

Signature of Parent or Guardian Date Print Name