



PERSONAL

Name: _____
Address: _____
Postal Code: _____
Telephone #: _____
Cell #: _____
Email: _____
Birth date: _____
Age: _____
Emergency Contact: _____
Telephone # (H): _____
Telephone# (W): _____
Email: _____

MEDICAL HISTORY

(medical exam within last 12 months is recommended)

Physician: _____
Address: _____
Postal Code: _____
Telephone #: _____
Fax #: _____
Date of last medical: _____
General Findings: _____
Previous Injuries: _____
Date of Injury: _____
Past Surgery: _____
Date of Surgery: _____
Physical Limitations: _____

Primary Diagnosis: _____

PHYSICAL HISTORY

Present recreational or athletic exercise activities: _____
Past recreational or athletic exercise activities: _____
What are your goals? (Health, Fitness, Performance): _____
What activities do you enjoy? _____
What activities would you prefer to avoid? _____
What days and times are best for you to exercise? _____

NUTRITION

Do you regularly eat (Y/N): Breakfast _____ Lunch _____ Dinner _____ Snacks _____
Have you ever been on a diet? _____ If yes, specify _____

HEALTH STATUS

From the best of your knowledge please specify if any of the following health problems apply to you, be specific

Cardiovascular (blood pressure, heart...?) _____
Respiratory (lungs) _____
Musculoskeletal (muscle) _____
Neurological _____
Gastro-intestinal _____
Blood disorder _____
Metabolic (diabetes, thyroid) _____
Skin _____
Previous illness affecting exercise? _____
Are you currently taking medication, prescription or non-prescription? _____
Medication name _____
Dosage _____