



Answer each question by printing the necessary information. Your answers are confidential.

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**In Case of Emergency, Please Notify:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**MEDICAL INFORMATION:**

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under the care of a physician, chiropractor, or other health care professional for any reason? **Yes No**

If yes, list reason: \_\_\_\_\_

Are you taking any medications? **Yes No**

*(if yes, complete the following)*

Type / Dosage & Frequency / Reason for taking: \_\_\_\_\_

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

Please list any allergies: \_\_\_\_\_

- |                                                                                                                          |            |           |
|--------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Has your doctor ever said your blood pressure was too high?                                                           | <b>Yes</b> | <b>No</b> |
| 2. Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise? | <b>Yes</b> | <b>No</b> |
| 3. Are you over age 65?                                                                                                  | <b>Yes</b> | <b>No</b> |
| 4. Are you unaccustomed to vigorous exercise?                                                                            | <b>Yes</b> | <b>No</b> |
| 5. Is there any reason not mentioned here why you should not follow a regular exercise program?                          | <b>Yes</b> | <b>No</b> |

If so, please explain. \_\_\_\_\_

6. Have you recently experienced any chest pain associated with either exercise or stress? **Yes No**

If so, please explain. \_\_\_\_\_

**Smoking**

Please check the box that best describes your current habits:

- Non-user or former user; Date quit: \_\_\_\_\_
- Cigar and/or pipe
- 15 or less cigarettes per day
- 16 to 25 cigarettes per day
- 26 to 35 cigarettes per day
- More than 35 cigarettes per day



**FAMILY & PERSONAL MEDICAL HISTORY:**

If there is a family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line.

- Asthma: \_\_\_\_\_
- Respiratory/Pulmonary Conditions \_\_\_\_\_
- Diabetes:     Type I         Type II        How long? \_\_\_\_\_
- Epilepsy:     Petite Mal     Grand Mal     Other: \_\_\_\_\_
- Osteoporosis: \_\_\_\_\_

**Lifestyle and Dietary Factors:**

- Occupation Stress Level:     Low     Medium     High
- Energy Level:                     Low     Medium     High
- Caffeine Intake/Daily: \_\_\_\_\_     Alcohol Intake/Weekly: \_\_\_\_\_
- Colds per Year: \_\_\_\_\_     Anemia: \_\_\_\_\_
- Gastrointestinal Disorder: \_\_\_\_\_
- Hypoglycemia: \_\_\_\_\_
- Thyroid Disorder: \_\_\_\_\_
- Pre/Postnatal: \_\_\_\_\_

**Cardiovascular:**

- High Blood Pressure: \_\_\_\_\_     Hypertension: \_\_\_\_\_
- High Cholesterol: \_\_\_\_\_
- Hyperlipidemia: \_\_\_\_\_
- Heart Disease: \_\_\_\_\_
- Heart Attack: \_\_\_\_\_     Stroke: \_\_\_\_\_
- Angina \_\_\_\_\_     Gout: \_\_\_\_\_

**MUSCULOSKELETAL INFORMATION:**

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

- Head / Neck: \_\_\_\_\_
- Upper Back: \_\_\_\_\_
- Shoulder / Clavicle: \_\_\_\_\_
- Arm / Elbow: \_\_\_\_\_
- Wrist / Hand: \_\_\_\_\_
- Lower Back: \_\_\_\_\_
- Hip / Pelvis: \_\_\_\_\_
- Thigh / Knee: \_\_\_\_\_
- Arthritis: \_\_\_\_\_
- Hernia: \_\_\_\_\_
- Surgeries: \_\_\_\_\_
- Other: \_\_\_\_\_



**NUTRITIONAL INFORMATION:**

Are you on any specific food / nutritional plan at this time?      **Yes**    **No**

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Do you take dietary supplements?      **Yes**    **No**

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Do you experience any frequent weight fluctuations?      **Yes**    **No**

Have you experienced a recent weight gain or loss?      **Yes**    **No**

If yes, list change: \_\_\_\_\_

Over how long? \_\_\_\_\_

How many beverages do you consume per day that contain caffeine? \_\_\_\_\_

How would you describe your current nutritional habits? \_\_\_\_\_

Other food/nutrition issues you want to include (*food allergies, mealtimes, etc.*)? \_\_\_\_\_

\_\_\_\_\_

**EXERCISE HABITS:**

Please check the box that best describes your work and exercise habits:

- Intense occupational and recreational exertion
- Moderate occupational and recreational exertion
- Sedentary work and intense recreational exertion
- Sedentary work and moderate recreational exertion
- Sedentary work and light recreational exertion
- Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Work:     Minimal     Moderate     Average     Extremely

Home:     Minimal     Moderate     Average     Extremely

Do you work more than 40 hours a week? \_\_\_\_\_

Please make any other comments you feel are pertinent to your exercise program. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Steele Fitness Trainer

\_\_\_\_\_  
Date