



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? | Yes | No |
| 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? | Yes | No |
| 3. Are you over age 65? | Yes | No |
| 4. Are you unaccustomed to vigorous exercise? | Yes | No |
| 5. Is there any reason not mentioned here why you should not follow a regular exercise program? | Yes | No |

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