



## Medical & Health History

Are you currently taking any medications or supplements?

Yes, Please List: \_\_\_\_\_

No

Please list any accidents or injuries (falls, auto, childhood, etc.) & dates of occurrences:

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

Please list any surgeries and dates of occurrences: \_\_\_\_\_

\_\_\_\_\_

If you are under a doctor's care, have you been released to exercise?  Yes  No

Do you now, or have you ever been treated for any of the following conditions?  
(Circle and explain where applicable)

Arthritis

Chronic Illness

Diabetes

Eating Disorder

Elevated Cholesterol

Heart Problems

Lung Problems

High Blood Pressure

Auto Immune Disease

Orthopedic Problems:

Back

Feet

Knee

Neck

Other \_\_\_\_\_

Any other conditions that may affect your exercise program:

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

**The information on this form is accurate to the best of my ability.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_