



## MEDICAL QUESTIONNAIRE

**Do you have any medical conditions that may prevent you from exercising?**

Yes  No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

**Is there any Family history of heart problems, Diabetes, cholesterol etc?**

Yes  No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_

**Do you suffer from any of the following?**

Asthma  Diabetes  Epilepsy   
High cholesterol  Arthritis  Chest pain   
Dizziness  High/low blood pressure  Heart problems   
Osteoporosis  Any other conditions

Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you have any joint problems, aches, pains or injuries (past or present)?**

Ankles  Back  Elbows   
Knees  Neck  Wrists   
Hips  Shoulders  Others

Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you take any medication, pills, supplements?**

Yes  No

If Yes, please list \_\_\_\_\_

\_\_\_\_\_

**When was your last Doctors visit and why?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you, or have you recently been pregnant?**

Yes  No

Describe:

\_\_\_\_\_

*We are happy to recommend that you consult with your Doctor before starting any exercise program. Thank-you for helping us to help you achieve your goals safely.*

**Are you currently exercising?**

Yes  No  Sometimes

*Please be aware that your Trainer will do everything to ensure that your exercise program is safe and effective, however you are choosing to exercise at your own risk and we appreciate you taking responsibility of your own body.*

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

Date \_\_\_\_\_