LeenFitness Personal Training Client Health History Form

Please answer each question by printing the necessary information. Your answers will be kept confidential.

Name:_____
Address:_____
D.O.B:_____
Phone Number :_____
Email Address:_____
Emergency Contact:_____
Emergency Contact Phone Number:_____
Height: _____
Weight: _____

General Medical History & Information

Are you under the care of a physician, chiropractor, or other health care professional for any reason?

If yes, list
reason:_____

Are you aware of any disease or disorder that would complicate your participation in a testing or exercise
program?_____

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by
exercise?_____

Are you taking any medications? If yes please indicate the type of medication, dosage, frequency

and reason(s) for taking it.
_____

Please list any
allergies_____
Has your doctor ever said your blood pressure was too high? _____
Are you over age 65? _____
Are you unaccustomed to vigorous exercise? _____

Is there any reason not mentioned here why you should not follow a regular exercise program?

If so, please explain
_____
_____

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
_____
Lower Leg / Ankle / Foot

Please circle any areas of pain, injury, tension, or restriction of movement.

Have you recently experienced any chest pain associated with either exercise or stress?

If so, please explain
_____
_____

Do you have a history of any of the following conditions?

Heart Disease _____ Heart Attack _____ Hypertension _____ Gout _____ Abnormal EKG _____ Asthma _____ High Cholesterol _____ Angina _____ Diabetes _____ Other heart conditions _____

Do you have a family history of cardiovascular disease? If so, how many occurrences and what approximate ages?
_____

Are you a smoker? If so, what is your smoking frequency? _____ Are you on any specific food / nutritional plan at this time? _____ Do you take dietary supplements? If yes, please list _____
_____

How many beverages do you consume per day that contains caffeine?
_____ _____

Do you experience any frequent weight fluctuations?
_____ ___

Have you experienced a recent weight gain or loss? If yes, list change
_____Over how long? _____

What would you like to improve about your body and over all health?

Do you have any negative feelings toward exercise?_____

_____

Your answers to these questions will be discussed with you prior to your session. Thank You.

Signature:_____ Date:_____