

Name of Participant:

Age:

Sex: Male Female

Day Phone:

Evening Phone:

Preferred Session Times:

Day _____ Time _____

Day _____ Time _____

Day _____ Time _____

Preferred Trainer: (check one)



Sheri
Palizzi



Paul
Riccardi



Suzi
Shankweiler



Kim
Street



Diana
Wiles

PARTICIPANT'S HEALTH HISTORY INFORMATION

Date:

Emergency Contact:

Name of Physician:

Relationship to Participant:

Physician's Phone:

Emergency Contact's Phone:

Are you taking any medications or drugs? Yes No

If yes, what are you taking? _____

Does your physician know you are taking part in this exercise program? Yes No

Describe your current exercise program: _____

Do you now have, or have you had in the past?

(Please explain "yes" answers on reverse side or on a separate sheet and attach to this form.)

- | | | |
|--|------------------------------|-----------------------------|
| 1. *History of heart problems, heart attack, chest pain or stroke? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. *Increased blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. *Diabetes or a thyroid condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. *History of heart problems in the immediate family? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Any chronic illness or condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Difficulty with exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Advice from physician not to exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Surgery within the last 12 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Pregnancy? (now or within the last 3 months) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. History of breathing or lung problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Muscle, joint, or back disorder, or any previous injury still affecting you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Cigarette smoking habit? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Obesity? (more than 20% over ideal body weight) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Increased blood cholesterol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Hernia or any condition that may be aggravated by lifting weights? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Have you had any pain or discomfort with exercising in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**If an asterisk question is marked yes, a physician's release form must be completed before personal training sessions can begin.*