Armstrong Integrative Movement, LLC

Holistic Personal Training Services
Move better…Live better.

HEALTH HISTORY EVALUATION FORM

Date: _____

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone: _____ _____ _____
Home *Work* *Emergency*

Email: _____ Date of Birth: _____ Age: _____

Medical History

Date of last physical exam: _____ Current body weight: _____

Blood pressure: _____

Current cholesterol level: _____ HDL: _____ LDL: _____ Triglycerides: _____

Are you presently taking medication? _____

If yes, please list medications:

_____

_____

Are you presently taking vitamin supplements? _____

If yes, please list vitamins:

_____

_____

Please check if you have had, or currently have any of the following:

☐ Heart attack, coronary bypass, or other cardiac surgery

☐ Chest discomfort, particularly with physical activity

☐ High blood pressure

☐ Extra, skipped, or rapid heartbeats/palpitations

☐ Recent car accident

☐ Ankle swelling

☐ Unusual shortness of breath

☐ Light-headedness or fainting

☐ Pulmonary disease, i.e. asthma, emphysema

☐ Diabetes

☐ Stroke

☐ Recent illnesses, hospitalization or surgeries

☐ Allergies

☐ Orthopedic problems: low back, ankles, neck, knees, hips, shoulders

Please explain any item you checked under "Medical History":

_____

_____

_____

Have you had any dental work done? Yes____ No____

If yes, please describe what kind and date(s)_____

_____

Do you wear contact lenses and/or eyeglasses? Yes____ No____

Exercise history

Please list all past and present activity you have engaged in:

_____

_____

_____

_____

Have you ever had an exercise-related injury(ies)?_____Yes _____No

If yes, please describe (be as specific as possible including type, location(s) on the body, date(s) of injury, etc.)_____

_____

_____

_____

Any Injury Treatment(s):

_____

_____

_____

Family Medical History

Please check if anyone in your family has had or presently has any of the following:

☐ Coronary disease

☐ Congenital heart disease

☐ Cancer

☐ Diabetes

Please explain any item that you checked:

_____

_____

Social Habits

Please check any of the following that apply:

☐ Caffeine (including cola drinks)

☐ Alcohol

☐ Tobacco

Amount and frequency: _____

Women Only

Please check any of the following that apply to you:

☐ Currently pregnant: Due Date: _____

☐ Hysterectomy

☐ Pre-menopause

☐ Menopausal

☐ Post-menopause

☐ C-Section

Acknowledgement

☐ I hereby acknowledge that I have carefully read the health history evaluation form and answered the questions truthfully. It is advised that if I answered "yes" to any of the questions on the health history evaluation form, I should consult a physician prior to starting an exercise program with a qualified health and fitness instructor.

☐ I understand the above questions and will act on my own accord in taking full responsibility for my actions in choosing to continue with a qualified health and fitness instructor without consulting my physician.

Client's Signature: _____ **Date:** _____

Trainer's Signature: _____ **Date:** _____