PERSONAL TRAINING INTAKE FORM

Full Name ______________________ Date ____________

What are your goals? ______________________

What are you currently doing for exercise? ______________________

Did/Do you participate in sports or other activities? ______________________

What do you do for work? Are there any repetitive movements involved?

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Have you been diagnosed or treated for?	Yes	No	If yes, explain
Heart condition or disease			
Arthritis			
Epilepsy/seizures			
Diabetes			
Asthma or other breathing challenges			
Chest pain			
Frequent dizziness or loss of balance			
Surgery within the last 12 months			
Muscle, joint, bone, or back pain that restricts your exercise			
High blood pressure or cholesterol			
Other			
Sedentary lifestyle (last 6 months)			
Do you smoke?			
Has anyone in your immediate family had a heart attack, stroke, or cardiovascular disease before age 55?			
Are you currently taking any medications or supplements? Please list names and purpose.			
Any other illness, conditions, or injuries?			

I verify the above statements to be true and understand that ***if I answered yes*** *to any of the questions that I should receive clearance from a doctor before beginning any exercise program.*

Signature ______________________

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