

**PREMIERE PERSONAL FITNESS, LLC**  
**HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**HEALTH REPORT**

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

- 1) Are you Currently taking any medication?  Yes  No  
Type: \_\_\_\_\_ Reason: \_\_\_\_\_  
Type: \_\_\_\_\_ Reason: \_\_\_\_\_  
Type: \_\_\_\_\_ Reason: \_\_\_\_\_

2) Do you have or have you ever had any of the following conditions?

| <b><u>CONDITION</u></b> |  | <b><u>DESCRIPTION</u></b> |
|-------------------------|--|---------------------------|
| Heart Attack            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Stroke                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Chest Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Hypertension            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Diabetes                | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Cancer                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| High Cholesterol        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Hernia                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Arthritis               | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Thyroid                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Anemia                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |
| Other                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     |

3) Have you ever been injured in any of the following areas?

| <b><u>BODY PART</u></b> |  | <b><u>DESCRIPTION</u></b> | <b><u>WHEN?</u></b> |
|-------------------------|--|---------------------------|---------------------|
| Neck                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     | _____               |
| Shoulders               | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     | _____               |
| Arms                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     | _____               |
| Abdomen                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     | _____               |
| Back                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     | _____               |
| Legs                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                     | _____               |

- 4) Are you currently under the care of a physician for any reason at all?  
 Yes  No If Yes, explain \_\_\_\_\_
- 5) Do you smoke cigarettes?  Yes  No. If yes, how much? \_\_\_\_\_
- 6) Do you know of any physical condition that you have that could be aggravated by exercising or exerting yourself?  
 Yes  No If Yes, explain \_\_\_\_\_
- 7) Are you taking any medication that could cause a reaction while exercising?  
Yes  No If Yes, Explain \_\_\_\_\_
- 8) Does your doctor know that you are beginning a new exercise program?  Yes  No
- 9) If your doctor knows that you are going to begin a new exercise program, does he/she object?  Yes  No If Yes, why? \_\_\_\_\_

**RELEASE**

I know of no physical or medical condition that I, or my Doctor, feel could be aggravated by my exercising or participating in activities instructed by my trainer. I agree to advise my trainer in writing if any of the above information changes or if my Doctor advises me to stop, reduce, or otherwise adjust my exercise regimen. I will advise my trainer immediately if I injure myself in anyway while exercising under his/her guidance. The information I have given on this form is, to the best of my knowledge, complete and accurate.

Signature \_\_\_\_\_ Date: \_\_\_\_\_ (Form #6A)