



CEi Fitness and Coaching Health History Questionnaire

Name _____

Address _____

Email address _____

Contact phone number(s) _____

Emergency contact _____

Emergency contact address and phone _____

Age _____ Birthdate _____

Family doctor _____

Family doctor's phone _____

Please read to following questions carefully and answer honestly to the best of your ability.

1. Do you smoke? Y N If so, how much _____
2. Has your doctor ever said your blood pressure was too high or low? Y N
3. Have you (or a family member) ever been told that you have diabetes? Y N
4. Do you have any known cardiovascular problems (abnormal ECG, previous heart attack, atherosclerosis, etc)
Y N If yes, please explain _____
5. Has your doctor ever told you that your cholesterol level was high? Y N
6. Are you overweight? Y N if so, how much? _____
7. Do you have any injuries or orthopedic problems (bursitis, back pain, knee pain, neck, shoulders, etc.)?
Y N if so, please explain _____
8. Are you taking any prescribed medications or dietary supplements Y N
If so, please explain _____
9. Are you pregnant or post-partum less than six weeks? Y N
10. Date of last physical exam _____
11. Do you have any other medical problems not previously mentioned? Y N IF so, please explain _____
12. Are you currently involved in a regular exercise program? Y N
13. What are your current exercise goals? _____
14. Have you had surgery in the past 3 months Y N
15. Have you been hospitalized in the past 2 years? Y N
16. If so, explain _____
17. Do you have any bone or joint problems or pain? Y N
18. If so, please explain _____

I, _____, acknowledge, to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in this exercise program. I certify that I understand the foregoing questions and my answers are true and compete. I also understand that this information is being provided as part of my initial consultation and may not be periodically updated.

I assume the risk for any changes in my medical condition that might affect my ability to exercise.

Signature Date

Signature of parent if client is a minor Date