



Medical and Injury History

Date: _____ Date of Birth: _____
 Name: _____ Gender: _____

List Three specific goals that you would like to achieve:

1. _____
2. _____
3. _____

Please respond to the following questions:

1. What physical activities do you regularly participate in: _____

2. What is your dominant hand? Left or Right (circle)

3. Please place the year in each of the boxes below that apply to you.

	Surgery	Bone Fracture	Joint Sprain Ligament Tear	Muscle/ Tendon Strain
Shoulder				
Back				
Abdomen				
Hip				
Groin				
Knee				
Ankle				
Foot				

4. Discuss in detail any of the injuries that you listed in the above boxes.

5. Do you find walking or climbing stairs uncomfortable?

Yes No

If "Yes," how many minutes can you walk before pain makes you uncomfortable?

Less than 2 minutes Between 3 and 5 minutes 6 to 9 minutes
 10 to 15 minutes More than 15 minutes.

6. Do you have stiffness or swelling in any of your joints?

Yes No

List joints affected: _____

7. Are you currently involved in any other training, conditioning or fitness programs?

Yes No

8. Are you currently on any type of medical or training restrictions?

Yes No

Give details: _____

9. Is there anything that is limiting your participation in physical activities including but not limited to walking, grocery shopping, driving, sports, etc.?

Yes No

If yes, please explain: _____

10. Please check box if you take medication for any of the following reasons:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diuretics
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Diabetes

Signature: _____