

Balance Living Personal Training

Details and Case History

Date: _____

Name: _____ D.O.B: _____

Address: _____

_____ Phone Number: _____

Emergency Contact Person and Phone Number: _____

Occupation: _____

Height: _____ Weight: _____ Children: _____

Fitness Goals/Aspirations: _____

G.P: _____

Physical Measurements (to be completed by your fitness instructor)

Height: _____ Weight: _____ BP: _____ RPR _____

Other: _____

HEALTH HISTORY

Are you currently taking any prescribed medication or supplements?

Could any of these medications/supplements cause a reaction whilst exercising? If yes please detail:

Are you currently under the care of a GP for any ongoing conditions?

Have you ever been advised by a healthcare professional not to exercise?

Do you know of any condition you have that could be aggravated by exercise or exertion? If yes please explain:

Do you have or have you ever had any of the following conditions:

Heart Attack

Stroke

Chest Pains

Hypertension (High BP)

Cancer

High Cholesterol

Diabetes

Thyroid Problems

Arthritis Hernia

Anaemia

Obesity

Breathing/Lung Problems

Other (please explain)

If you answer yes to any of the above - please give a description:

Have you suffered injury in any of the following areas? If yes please give details:

Neck

Shoulders Arms/Hands

Abdomen

Back

Legs/Feet

Are you or have you been pregnant within the last 3 months?

Do you drink alcohol - if yes how many units per week?

Do you smoke - if yes how much?

Do you take recreational drugs?

If you have answered yes to any of the above it may be necessary to obtain a GP Release form prior to fitness assessment.

The information I have given on this form is, to the best of my knowledge, complete and accurate

Signature:

Print Name:

Date: