16719 110th Ave. E
Puyallup, WA 98374
(253) 840-8581
Fax: (253) 848-1908

Client Medical History

First Name: ________________________ Last Name: ________________________

Date of Birth: ______/______/________ Age ________

Level of Activity (check one): ( ) Sedentary ( ) Mildly Active ( ) Active ( ) Very Active

Describe your activities: ____

____

Are you taking any medications or drugs? If so, please list medication, dose and reason. ______________

____

Does your physician know you are participating in this exercise program? ( ) Yes ( ) No

Do you now, or have you had in the past:

1.	History of heart problems, chest pain or stroke?	Yes ______	No ______
2.	Increased blood pressure?	Yes ______	No ______
3.	Any chronic illness or condition?	Yes ______	No ______
4.	Difficulty with physical exercise?	Yes ______	No ______
5.	Recent surgery (last 12 months)?	Yes ______	No ______
6.	Pregnancy (non or within last 3 months)?	Yes ______	No ______
7.	History of breathing or lung problems?	Yes ______	No ______
8.	Muscle, joint, or back disorder or any previous injury still affecting you?	Yes ______	No ______
9.	Diabetes or thyroid condition?	Yes ______	No ______
10.	Cigarette smoking habit?	Yes ______	No ______
11.	Increased blood cholesterol?	Yes ______	No ______
12.	Hernia, or any condition that may be aggravated by lifting weights?	Yes ______	No ______
13.	Feelings of faint or spells of dizziness?	Yes ______	No ______

Please explain any *Yes* answers in the *Comments* section below and on the back of this paper. Make sure to note any injuries, sprains, or pains you might have.

Comments: ____

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____ ______/______/________
(Signature of Client) (Date)

____ ______/______/________
(Signature of Parent/Legal Guardian) (Date)

(Rev. 8/06)