Consultation form

Name:

Date:

Age:

Weight:

Describe your exercise program now?

My goals are?

My time commitment is?

Please answer Yes or No to the following questions.

1. Do you now, or have you had a in the past Heart problems, chest pain or stroke?
2. Increased blood pressure?
3. Any chronic illness or condition?
4. Any physical limitations or past injuries that required surgery?
5. Any illnesses for example; Asthma, Diabetes, hypoglycemia?
6. Muscle, joint, or back disorders?
7. Cigarette smoking habit, Caffeine, or Alcohol?

Please explain any Yes answers below.
Explain:

Are you currently taking any medications or drugs? If so, what?

Has a doctor placed any restrictions on you concerning exercise?
If so please explain: