General Information and Health History Form
Fitness Training by Jacob Dickson

Name: Date:

Address:

Phone Numbers (please indicate preferred contact number or times to call):
Mobile: Home:

Work: Other:

Email: Age: Birthday:

Emergency Contact: Telephone:

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

____ 1. History of heart problems, chest pain, or stroke _____
____ 2. Increased blood pressure. _____
____ 3. Any chronic illness or condition. _____
____ 4. Difficulty with physical exercise _____
____ 5. Advice from a physician not to exercise. _____
____ 6. Recent surgery (past 12 months) _____
____ 7. History of breathing or lung problems _____
____ 8. Muscle, joint, or back problems, or any previous injury still affecting you _____
____ 9. Diabetes or thyroid condition _____
____ 10. Cigarette smoking habit _____
____ 11. More than 20% over ideal weight _____
____ 13. History of heart problems in immediate family _____
____ 14. Hernia, or any condition that may be aggravated by weightlifting _____

List number of alcoholic drinks per week _____

List any medications or drugs that you take _____

_____

Additional comments, or information your trainer should know: _____

_____

_____

_____

Signature: _____