NEW PERSONAL TRAINING CLIENT HEALTH HISTORY FORM

Name: ____ Phone Number: ____

Address: ____ City, State, Zip: ____

Birthday: ________ Occupation: _______________________ E-mail: ____

Emergency Contact Name: __________________________________ Phone: _____________________________

☐ Check the box to NOT be signed up for The Metta Center's monthly e-newsletter

Who can we thank for referring you? (Specify friend, website or other source) _____________________________________

Lifestyle/Background

Have you ever worked with a personal trainer before?

____

What would you like to focus on in your session(s)? What is your fitness goal?

____

Please summarize your daily routine, include fitness and nutrition:

____

____

____

Do you participate in any hobbies/sports? Yoga?

____

Medical Background

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered 'YES' to one or more of these questions, consult your physician BEFORE engaging in physical activity. Tell your physician which questions you answered 'YES' to. After a medical evaluation, seek advice from your physician on what type of activity is suitable to your current condition.

____

Office Use Only: ☐ Vagaro: Info Entered ☐ Added to Mailchimp ☐ Referral email sent ☐ Scanned to computer

Do you have any allergies? ____

List any current injuries or surgeries in the past 20 years; please describe them in detail.

____

____

Are you currently in any pain? If yes, where and how severe is it? Do you know what the cause is?

____

____

List any medications you are currently taking:

____

____

Do you have any of the following?
□ Arthritis □ Asthma □ Blood Clots □ Bursitis □ Cancer □ Cold/Flu Symptoms □ Diabetes □ Fibromyalgia
□ Headaches □ Heart Conditions □ High Blood Pressure □ Infections □ Neck/Back/Spine Condition □ Osteoporosis
□ Current Pregnancy-Due date:_________ □ Skin Disorders □ Ulcers

Other, please describe: ____

I understand I will notify The Metta Center LLC if any of my above medical conditions change. I will inform the instructor if I am uncomfortable in any position in the training session. It is my responsibility to obtain approval from my doctor if I have any concerns or medical conditions prior to receiving any of the services at The Metta Center. Furthermore, I will not hold The Metta Center or any of its practitioners liable for any injury.

Signature____ Date:________________

--------------------------*if under the age of 18, signature of parent/legal guardian is required--------------------------------

Signature____ Date:________________

Print Name: _______________________________________ Cell: _____________________________

Email: ____