



VitalityFitness

training that moves you

Vitality Fitness
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Medical History

In order to design a safe and effective program it is important that you complete the following form. It is crucial that you answer all the questions honestly and to the best of your ability. Please be advised that all information is kept strictly confidential.

Name _____ Date _____

Phone _____ Cell _____ Address _____

City _____ Zip Code _____

E-mail _____

Date of Birth _____ Age _____ Height _____ Weight _____

In case of emergency contact _____ Relationship _____

Phone _____

Are you currently under a doctor's care? Yes ___ No ___

If yes, please explain _____

What is your doctor's name? _____ Phone _____

Are you presently: ___ Single? ___ Married? ___ Divorced? ___ Widowed? ___ Separated?

Read all questions. Please check the appropriate response.

Yes No

1. Has your doctor ever told you that you have heart problems? _____

2. Has your doctor ever told you that you have high blood pressure? _____

3. Have you ever had a stroke or heart attack? _____

4. Have you ever had pain in your chest? _____

5. Do you ever feel faint or have dizzy spells? _____

6. Have you had surgery in the last six months? _____

Please check the appropriate conditions, past or present.

___ Diabetes ___ Epilepsy ___ High blood pressure ___ Asthma ___ Arthritis

___ High Cholesterol ___ Depression ___ Fibromyalgia ___ Vertigo ___ Obesity

___ Anxiety ___ Other _____



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If checked, please explain _____

Have you injured or do you currently have pain in the following areas? Check all that apply.

Neck Upper Back Shoulders Elbows Lower Back
 Hips Wrists Knees Other _____

If checked, please explain _____

Are you currently taking any medications? Yes No

If you checked "yes," please list medications, dosages, and for what condition.

Medication _____ Dosage _____ Condition _____

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Are you currently undergoing treatment from any of the following?

Physiotherapist Chiropractor Counselor Massage Therapist

If checked, please explain _____

What is your current exercise level?

6-7 times per week 4-5 times per week 2-3 times a week 0-1 times a week
 Not sure None

What types of exercise? (i.e. spin classes, weight training, walking, etc.)

How would you rate your level of stress on a daily basis?

Low Moderate High



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What do you think your ideal weight should be? _____

Are you currently following any type of special diet? ___ Yes ___ No

If yes, please explain _____

Approximately how many meals do you usually eat per day? _____

How many times per week do you usually eat the following? (Please list a number)

___ Beef ___ Fish ___ Fried foods ___ Fast foods ___ Desserts
___ Chips ___ Candy ___ Soda ___ Chewing tobacco

Do you usually abstain from extra sugar usage? ___ Yes ___ No

Do you usually eat salt at the table? ___ Yes ___ No

Do you eat differently on weekends as compared to weekdays? ___ Yes ___ No

Do you drink alcohol? ___ Yes ___ No

If yes, how much? ___ every night or day ___ 2-3 times per week ___ Once a week ___ Never

Do you smoke cigarettes, cigars, or a pipe? ___ Yes ___ No

If yes, how many per day? _____

Estimate how many hours of sleep you get each night _____

Are there any other reasons (health or personal) that may limit you from entering a exercise program?

