



Application and Health History 8/03

Name _____ Date _____

Address _____ City _____ St _____ Zip _____

Telephone (H) _____ (W) _____ (C) _____

Sex M F Date of Birth ____/____/____ E-mail _____

Person to contact in case of emergency:

Name _____ Relationship _____ Phone _____

Personal Physician _____ Phone _____

Address _____

In order to design a safe and effective program, it is important that you answer the following questions honestly and to the best of your ability.

Are you currently taking any medications? Y N (if yes, please list below)

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Please check any of the following conditions that you have now or have ever had:

- | | | |
|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Severe headaches | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Pain/swelling in joints | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Swelling of feet/ankles | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Psychological difficulties | <input type="checkbox"/> Alcoholism/drug abuse | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Use of laxatives/water pills | <input type="checkbox"/> Hernia | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Cigarette smoking habit | <input type="checkbox"/> Other _____ | |

Please answer the following health related questions:

- Have you had any recent illness, hospitalization or surgical procedures?(last 12 months)
Y N (if yes, please explain) _____

- Are you pregnant? Y N

- Do you have a family history of heart disease, high blood pressure, heart attacks, or sudden death? Y N (if yes, please explain) _____

- Are you currently in therapy or have you received counseling in the past? Y N (if yes, please explain) _____

Please answer the following questions concerning your exercise and diet history:

- Are you currently exercising? Y N (if yes, please specify the type of exercise)
_____minutes/day _____days/week

- Have you exercised in the past six months? Y N

- Do you have any negative feelings toward exercise or fitness in general or have you had any bad experiences in the past concerning exercise or fitness? Y N
(if yes, please explain) _____

- Are you currently following a specific nutrition plan? Y N (if yes, please explain the type and how much weight you have lost) _____

- Have you dieted in the past year? Y N (if yes, please specify type and how much you lost)

- Do you have trouble sticking to an exercise or nutritional program once you start? Y N
(if yes, please explain why it is hard for you) _____

Waiver of Liability: It is further expressly agreed that all exercise, treatments and use of equipment and facilities at Institute of Athletic Development are and shall be undertaken at client's sole risk, and that clients assumes risk of any injuries he or she may suffer while using any of the equipment or the facilities of Institute of Athletic Development, and that Institute of Athletic Development shall not be liable for any claims, demands, injuries, damages, actions or causes of action, whatsoever to the client or property arising out of or connected with the use of the services, equipment and/or facility of Institute of Athletic Development and the client does hereby expressly forever release and discharge Institute of Athletic Development from all such claims, demands, injuries, damages, actions or cause of action, and from all acts of negligence, active or passive, and all other fault, on the part of Institute of Athletic Development, its servants or employees.

Signed _____ Date _____

I acknowledge that I have read over and certify that answers given herein are true and accurate to the best of my knowledge.

Signed _____ Date _____