

Client Health History Form

Date: _____

Surname: _____ Given name: _____

Address: _____

Suburb: _____ Postcode: _____

Home Phone: _____ Mobile Phone: _____

Date of Birth: _____ Email: _____

Current exercise activities: _____

Past surgeries/injuries/accidents (Please specify): _____

Medications: _____

Please tick the following conditions you are experiencing or those that you have experienced in the past:

- | | |
|--|--|
| <input type="checkbox"/> Acute joint problems i.e. arthritis or acute rheumatoid arthritis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Metallic or synthetic implants such as a pacemaker or IUD | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Recent Thrombosis or possible thrombotic disorders | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Back problems such as hernia, discopathy or spondylosis | <input type="checkbox"/> Intense migraines |
| <input type="checkbox"/> Joint implants such as foot, knee or hip implants | <input type="checkbox"/> Serious Diabetes |
| <input type="checkbox"/> Heart Valve disorders/heartbeat irregularities | <input type="checkbox"/> Cardiovascular disease |
| <input type="checkbox"/> Acute inflammations or infections | <input type="checkbox"/> Gallstones or Kidney Stones |

If you have ticked any of the above, please provide details below:

I _____ release the trainer from any and all liability from problems arising from the exercise session/s as a result of information not given or incorrectly given in this health history.

Signature: _____ Date: _____