Medical History Form

Name: _____

Date of Birth: _____ Age: _____

Sex: M F Height: _____ Weight: _____ SVC Member: Y N

Address: _____

Telephone Number: _____ Email: _____

Emergency Contact: _____ Relation: _____

Contact Number: _____

_____

Pain/Injuries: _____

_____

_____

Surgeries: _____

_____

_____

Known Medical Conditions: _____

_____

Medication (Supplement): _____

Reason: _____

Medication (Supplement): _____

Reason: _____

Medication (Supplement): _____

Reason: _____

How many hours a day do you spend sitting (including work, driving, eating and relaxing)? _____

Have you been active in the past year? _____ If yes, how often do you exercise per week? _____

If no, how long have you been inactive? _____

On a scale of 1-10 (1 being very low), rate your fitness level: _____

What are your goals? _____

_____

_____

_____

Are you currently able to regularly visit a gym? Y N If so, where? _____

If no, what equipment is available to you? _____

Have you previously worked with a trainer? Y N

If so, when? _____ How often did you meet? _____

Do you: ____ Take a multivitamin daily ____ Take fish oil daily ____ Sleep an average of 7 hours/night

How did you hear about us? ____ Newsletter ____ SVC Website ____ Internet Search Engine

____ Friend ____ Flyer ____ Other: _____

By signing below, I attest that the information stated above is an accurate and correct reflection of my current health status.

Print Names: _____ Date: _____

Signature: _____

Additional Comments: