

HABITS

1. On average, how many hours of sleep do you get each night?
2. How many meals do you eat daily?
3. What kinds of foods do you eat on a regular basis?
4. Do you have any dietary restrictions or allergies?
5. Do you prefer to listen to music while you exercise? If so, what kind?

MEDICAL HISTORY

Please circle, if applicable, any of the following health problems you have had that have been diagnosed or treated by a health professional:

Orthopedic Problems	Injuries to Back, Knees, Ankles	Brain Concussion/Head Injury		
Epilepsy	Loss of Consciousness	High Stress	Chest Pain	Heart Murmur
High Blood Pressure	Heart Attack/Stroke	Heart Rhythm Abnormality		
Any Type of Heart Problem	Disease of Arteries	High Cholesterol	Varicose Veins	

Lung Disease Rheumatic Dizziness Problems with Balance/Vertigo
Hypoglycemia Arthritis Diabetes Allergies

FAMILY HISTORY

Please circle all applicable medical issues that that exist in your family:

Heart Attack High Blood Pressure Diabetes Congenital Heart Disease
Heart Operation High Cholesterol Epilepsy Other_____

WAIVER

I, the undersigned, have read, understand, and have answered the above health/medical survey questions fully and truthfully. I am aware of my responsibility to consult with my personal physician regarding my medical fitness to engage in strenuous exercise and a nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the participating training facility, and the fitness trainer administering this instrument for any and all injuries suffered while following the training and/or nutrition program provided to me.

Client's Signature_____

Print Client's Name_____

Parent/Legal Guardian's Signature*_____

*If Client is under 18 years of age, the parent or legal guardian must sign