



# Kasey Olson - CFT

## Health History Form

CLIENT NAME: \_\_\_\_\_

ADDRESS:

\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

\_\_\_\_\_

EMAIL: \_\_\_\_\_

PHONE:

\_\_\_\_\_

Physician: \_\_\_\_\_

PHONE:

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_

PHONE:

\_\_\_\_\_

**1. Are you currently taking any medication?**

**YES**

**NO**

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

Medication: \_\_\_\_\_

Reason: \_\_\_\_\_

**2. Do you have or have you ever had any of these?**

CONDITION	(Circle One)	Description/When
Heart Attack	YES NO	_____
Stroke	YES NO	_____
Chest Pain	YES NO	_____
Hypertension	YES NO	_____
Diabetes	YES NO	_____
Cancer	YES NO	_____
High Cholesterol	YES NO	_____
Hernia	YES NO	_____
Arthritis	YES NO	_____
Thyroid	YES NO	_____
Anemia	YES NO	_____

**3. Have you ever been injured or had surgery in/on any of the following areas?**

LOCATION	(Circle One)	Description/When
NECK	YES NO	_____
SHOULDERS	YES NO	_____
ARMS	YES NO	_____
ABDOMEN	YES NO	_____
BACK	YES NO	_____
LEGS	YES NO	_____
OTHER	YES NO	_____

**4. Are you currently under the care of a physician for any specific reason at all?**

YES NO

If yes, please explain: \_\_\_\_\_

**5. Do you smoke cigarettes?**

YES NO

If yes, list amount: \_\_\_\_\_

**6. Do you know of any physical condition that you have that could be aggravated by exercising?**

YES NO

If yes, please explain: \_\_\_\_\_

**7. Are you taking any medication which could cause a reaction while exercising?**

YES NO If yes, list amount: \_\_\_\_\_

**8. Does your doctor know that you are beginning a new exercise program?**

YES NO

**9. If your doctor does know that you are beginning a new exercise program, does he/she object?**

YES NO If yes, please explain: \_\_\_\_\_

**GENERAL RELEASE**

I know of no physical or medical condition which I or my physician feel could be aggravated by my implementation of an exercise regimen as set for by "Kasey Olson - Certified Fitness Trainer." I agree to advise "Kasey Olson - Certified Trainer" if any of the above provided information changes or if my physician advises me to stop, reduce or otherwise adjust my exercise regiment as provided. I will furthermore advise "Kasey Olson - Certified Fitness Trainer" and necessary club management personnel immediately should I injure myself in any way while performing my workout. The information I have given on this form is, to the best of my knowledge, complete and accurate.

**CLIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**MEDICAL RELEASE**

1. In consideration of being allowed to participate in the workout activities, dietary assistance and exercise programs set forth by "Kasey Olson - Certified Fitness Trainer", I do hereby waive, release and forever discharge "Kasey Olson - Certified Fitness Trainer" from any and all liability from injuries or damages resulting from my participation in any such activities. I do also hereby waive, release and forever discharge the facility and it's owners, agents and representatives in which said activities are/were performed.

2. I understand and am aware that strength, flexibility and aerobic exercise (including the use of equipment) is potentially hazardous activity. I also understand that fitness activities involve a risk of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume any and all risks of injury or death.

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in such workout activities, dietary assistance, exercise programs or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly (or more frequent) physical examination and consultation with my physician as it pertains to physical activity, exercise and use of exercise and training equipment so that I might have his/her recommendations concerning these fitness activities and equipment usage. I acknowledge that I have either had a physical examination and been given my physician's permission to participate, or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities and utilization of equipment and machinery in any activities.

**CLIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_