Medical History Date: _____

Name: _____ Age: _____ Phone #: _____

1) Did you consult with a physician prior to beginning this program? Yes No

2) Do you take any medications? Yes No

If yes, please list: _____

3) Do you have any cardiac or respiratory diagnoses or concerns? Yes No

If yes, please list: _____

4) Are there any other medical diagnoses or concerns we should be aware of? Yes No

If yes, please list: _____

5) Do you frequently experience any of the following?

Chest Pain	Yes	No
Shortness of Breath	Yes	No
Extreme Fatigue	Yes	No
Fainting Spells	Yes	No
Swelling of Hands or Feet	Yes	No
Arm/Leg Pain	Yes	No
Back Pain	Yes	No
Knee/Ankle Pain	Yes	No

Please explain any yes answers: _____

_____

I understand that by engaging in a fitness program through Abilities Movement, Inc., I will be participating in health enhancing activities. I understand that there are risks involved with resistance training, cardiovascular and stretching activities. I agree that all instruction and use of all facilities shall be undertaken at my own risk and that I am physically able to undertake any and all instruction provided.

Participant:_____Date: _____