



[HTTP://WWW.RITCHSPERSONALTRAINING.COM/](http://www.RITCHSPERSONALTRAINING.COM/)

Basic Information:

Name: _____ Date of Birth ___/___/___

Address: _____ City: _____

Zip: _____ E-mail: _____

Phone: (H) _____ (C) _____

Gender: _____ Occupation: _____

Emergency Contact: _____ Phone# _____

Medical History:

Do any of the following occur during exercise:

- | | |
|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint Discomfort |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Bladder Control |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Drop in Blood Sugar |

Have you been diagnosed with:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypo/Hyperthyroidism |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood Clots |

Have you had any:

- | | |
|---|--|
| <input type="checkbox"/> Joint Surgery or Replacement | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Shunts Placed | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Dislocated Joints |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Torn Ligaments |

Are you Pregnant? Y N _____wks

Please elaborate on any items checked _____

List any medications you are taking _____