RITCH'S PT

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:

- ◊ Dizziness
- ◊ Chest Pain
- ◊ Shortness of Breath
- ◊ Fainting
- ◊ Joint Discomfort
- ◊ Nose Bleeds
- ◊ Loss of Bladder Control
- ◊ Drop in Blood Sugar

Have you been diagnosed with:

- ◊ High Blood Pressure
- ◊ Low Blood Pressure
- ◊ Diabetes
- ◊ Osteoporosis
- ◊ Asthma
- ◊ Seizures
- ◊ Hypo/Hyperthyroidism
- ◊ Chest Pain
- ◊ Vertigo
- ◊ Fibromyalgia
- ◊ Arthritis
- ◊ Blood Clots

Have you had any:

- ◊ Joint Surgery or Replacement
- ◊ Shunts Placed
- ◊ Heart Surgery
- ◊ Miscarriage
- ◊ Pacemaker
- ◊ Broken Bones
- ◊ Dislocated Joints
- ◊ Torn Ligaments

Are you Pregnant? Y N _____wks

Please elaborate on any items checked_____

_____

List any medications you are taking_____