

**Coach Bennett Personal Training/Pilates  
Medical History**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

Date \_\_\_\_\_  
Home phone \_\_\_\_\_  
Work phone \_\_\_\_\_

1.) Do you have history of

- |   |   |
|---|---|
| <input type="checkbox"/> rheumatic fever        | <input type="checkbox"/> heart attack               |
| <input type="checkbox"/> thrombophlebitis       | <input type="checkbox"/> heart murmur               |
| <input type="checkbox"/> angina/chest pain      | <input type="checkbox"/> asthma                     |
| <input type="checkbox"/> high cholesterol       | <input type="checkbox"/> abnormal electrocardiogram |
| <input type="checkbox"/> fixed rate pacemaker   | <input type="checkbox"/> disease of arteries        |
| <input type="checkbox"/> heart medications      | <input type="checkbox"/> embolism                   |
| <input type="checkbox"/> high blood pressure    | <input type="checkbox"/> low blood pressure         |
| <input type="checkbox"/> varicose veins         | <input type="checkbox"/> valve disease              |
| <input type="checkbox"/> respiratory infections | <input type="checkbox"/> stroke                     |
| <input type="checkbox"/> aneurysm               | <input type="checkbox"/> irregular heart beats      |
| <input type="checkbox"/> epilepsy               | <input type="checkbox"/> rapid heart beats          |
| <input type="checkbox"/> anemia                 | <input type="checkbox"/> diabetes                   |

2.) Has your physician ever advised you not to exercise  yes  no  
If yes, please explain \_\_\_\_\_

3.) Do you have any of the following, which may limit your physical activity?

- |   |  |
|---|--|
| <input type="checkbox"/> arthritis                | <input type="checkbox"/> low back pain     |
| <input type="checkbox"/> shoulder/clavicle injury | <input type="checkbox"/> knee/thigh injury |
| <input type="checkbox"/> arm/elbow injury         | <input type="checkbox"/> nerve damage      |
| <input type="checkbox"/> upper back injury        | <input type="checkbox"/> head/neck injury  |
| <input type="checkbox"/> hip/pelvis injury        | <input type="checkbox"/> ankle/foot injury |
| <input type="checkbox"/> wrist/hand injury        | <input type="checkbox"/> bone fracture     |
| <input type="checkbox"/> other _____              |  |

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

4.) Do you ever experience any of the following when exercising or climbing stairs?

- |   |                                    |
|---|------------------------------------|
| <input type="checkbox"/> chest pain/ discomfort | <input type="checkbox"/> leg aches |
| <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> a "tired out" feeling  |                                    |

If so, please provide a physician's release prior to activity participation

Please date and sign this document in the spaces provided below and return this and any necessary physicians release forms to Yvonne Bennett, Coach Bennett Life Coaching & Personal Training Services

Participants Signature \_\_\_\_\_

Date \_\_\_\_\_

Fitness Personnel  
Signature \_\_\_\_\_

Date \_\_\_\_\_