HIGH OCTANE TRAINING
Karin DeLuca, Ace Certified Personal Trainer
Brief Health Assessment Profile Form

Name of Participant: Date of Birth:

Address: City, State & Zip Code:

E-mail Address: Phone Number:

Emergency Contact Name, Relationship, and Phone Number:

Signature of Participant (or Guardian if <18):

Today's Date:

MEDICAL HISTORY: Please place an "X" next to ANY/ALL that apply.

	Seen by a physician in the past year.		Have asthma. If yes, do you carry an inhaler?
	Cleared by a physician to exercise.		Have arthritis. If yes, please explain:
	Have diabetes.		Taking blood thinners. If yes, explain:
	Have high blood pressure or high cholesterol.		Had a heart attack. Date(s):
	Had a stroke. Date(s):		Diagnosed with heart disease.
	Currently pregnant. If yes, how many weeks?		Previous or current chest pain or numbness. If yes, explain:
	Given birth within the last 6-8 weeks.		Any History of Seizures. If yes, explain:
	Smoke. How much/often?		Drink alcohol. How much/often?
	Recent/past surgeries. List dates & explain:		Recent fracture(s), sprain(s), strain(s), or dislocation(s). Please explain in detail:
	Allergies. Please list ANY and ALL to foods, medications, insect bites, etc.		Please list the names of ANY and ALL prescription and/or over the counter MEDICATIONS you are currently taking:

Please describe any exercises/movements that cause you pain or discomfort AND any restrictions from your doctor:

Please notify me immediately if any of the above health conditions listed or explained on this form change