HEALTH AND FITNESS ASSESSMENT FORM

BODYTRIO

Name: _____
First Middle Last

Address: _____
Street Address City Country Zip

Phone: _____ Email: _____ Date of Birth: _____

How did you hear from us? _____

Have You Ever Been Treated by a Physician For:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Cardiovascular
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Low Blood Pressure
- ☐ Migranes or Recurrent Headaches
- ☐ Multiple Sclerosis
- ☐ Orthopedic/Joint Problems (shoulder/elbow/spine/hip/knee)
  - ☐ Anterior Cruciate Ligament Knee Injuries
  - ☐ Facet Joint Syndrome
  - ☐ Herniated or Bulging Disc
  - ☐ Spondylolisthesis
  - ☐ Stenosis
- ☐ Total Hip Replacement
- ☐ Osteoporosis
- ☐ Peripheral Neuropathy (numbness/tingling/diminished sensation)
- ☐ Rheumatoid Arthritis
- ☐ Other _____

Date of Last Physical Exam: _____

Are you pregnant? ☐ Yes ☐ No

Prior Deliveries: _____

Prior Surgeries: _____

_____

_____

Prior Injuries, Musculoskeletal and Neuromuscular Issues:

- ☐ Adhesive Capulitis (frozen shoulder)
- ☐ Carpal Tunnel Syndrome
- ☐ Plantar Fascitis
- ☐ Rotator Cuff Impingement
- ☐ Thoracic Outlet Syndrome
- ☐ Other _____

_____

_____

Current Medications: ☐ Yes ☐ No

Activity Level/Exercise Frequency:

_____

Prior Movement Experience (dance, yoga, pilates, gym):

_____

_____

Goals:

_____

Consent: I acknowledge to the best of my ability, that I am in good health and have no known medical problems that would restrict my ability to participate in this exercise program

_____ _____
SIGNATURE DATE