

Comox Community Centre

www.comox.ca * 1855 Noel Ave, Comox BC * 250-339-2255

Trainer Requested: _____

of Sessions: _____

Clerk Initials: _____

FITNESS STUDIO HEALTH SCREENING FORM

Comox Fitness Training Sessions

Date Received: _____

Name: _____

Phone: _____

Address: _____

Postal Code: _____

Occupation: _____

Date of Birth: _____

Age: _____

Physician's Name: _____

Physician Phone: _____

Date of last medical: _____

Please answer the following to ensure the best program suited to your needs.

#1 Are you taking any medications or drugs? YES NO

Please list: _____

#2 Does your physician know you are participating in this exercise program? YES NO

#3 Do you now, or have you in the past had:

- | | | | |
|---|--|-----|----|
| a | History of heart problems, chest pain or stroke? | YES | NO |
| b | Diagnosed high blood pressure or on hypertensive medication? | YES | NO |
| c | Increased blood cholesterol (greater than 240 mg/dl)? | YES | NO |
| d | Muscle, joint, or back disorder, or any previous injury affecting you? | YES | NO |
| e | Advice from your physician NOT to exercise? | YES | NO |

#4 Do you now, or have you in the past had:

- | | | | |
|---|---|-----|----|
| a | Any chronic illness or condition, or any form of arthritis? | YES | NO |
| b | Difficulty with physical exercise? | YES | NO |
| c | Recent surgery including hip or knee replacement? (last 12 months) | YES | NO |
| d | Pregnancy (now or within last 3 months) | YES | NO |
| e | History of breathing or lung problems? | YES | NO |
| f | Over the age of 65 & unaccustomed to vigorous exercise? | YES | NO |
| g | Obesity (more than 35 lbs over ideal body weight) | YES | NO |
| h | Hernia, or any condition that may be aggravated by lifting weights? | YES | NO |
| i | Diabetes? | YES | NO |
| j | History of heart problems in parents or siblings before age 55? | YES | NO |

If you have circled "YES" to ANY of the questions in #3 or two or more in #4 we suggest that you have a Medical Release form completed by your healthcare practitioner, and that you use a trainer that has his/her Medical Specialist Certificate.

#5 Please explain any questions you circled YES to in questions #3 & #4, or explain anything else we should know to design a suitable fitness program for you.

#6 Are you currently involved in regular endurance (cardiovascular) exercise? YES NO

If yes, please specify:

type: _____ days/week: _____ minutes/day: _____

type: _____ days/week: _____ minutes/day: _____

type: _____ days/week: _____ minutes/day: _____

#7 What are your 3 main personal health/fitness goals (ie. What are your reasons for having this personal consultation?)

a _____

b _____

c _____

#8 Preferred appointment time for your consultation:

MON ___ TUES ___ WED ___ THU ___ FRI ___ SAT ___

Mornings - Preferred time: _____

Afternoons - Preferred time: _____

Evenings - Preferred time: _____

Client Signature: _____

If client is under the age of 19 a parent or guardian signature is required as well.

Parent/Guardian Signature: _____

Thank you! A fitness trainer will be phoning you within ONE WEEK to set up an appointment for your fitness training session(s).

Additional space for trainer or office notes:
