Self Assessment

Your Name

E-mail

Telephone

Home Or Mailing Address

Date

Age

Physician's Name

Physician's Phone

Person To Contact In Case Of Emergency (Include Phone Number)

Persciptions

Are You Taking Any Medications Or Drugs? Please List Medications & Explanation Here

Does Your Physician Know You're Participating In This Exercise Program

Please Describe Any Physical Activity You Do Somewhat Regularly Here

Do You Now, Or Have You Had In The Past (Please Select All That Apply From The List Below)

- [ ] History Of Heart Problems, Chest Pain Or Stroke
- [ ] Increased Blood Pressure
- [ ] Any Chronic Illness Or Condition
- [ ] Difficulty With Physical Exercise
- [ ] Advice From Physician Not To Exercise
- [ ] Recent Surgery (Last 12 Months)
- [ ] Pregnancy (Now Or Within The Last 3 Months)
- [ ] History Of Breathing Or Lung Problems
- [ ] Muscle, Joint Or Back Disorder, Or Any Previous Injury Still Effecting You
- [ ] Diabetes Or Thyroid Condition
- [ ] Cigarette Smoking Habit
- [ ] Obesity (More Than 29% Over Ideal Body Weight
- [ ] Increased Blood Cholesterol
- [ ] History Of Heart Problems In Immediate Family
- [ ] Hernia, Or Any Condition That Might Be Aggravated By Lifting Weights
- [ ] None Of The Above

Please Explain Any Yes Answers Above Here

Please Use This Area For Any Additional Comments Or Information

Thank You For Your Time Filling Out This Form