

# Inursha Fitness & Personal Training

## Member Information & Health History Inquiry

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_ Work # \_\_\_\_\_

Employer \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

### Emergency Contacts

(1) Name \_\_\_\_\_ Phone \_\_\_\_\_

(2) Name \_\_\_\_\_ Phone \_\_\_\_\_

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Please answer all the questions so that we may know all that we need to know. This information will aid us in providing you with service and quality that exceeds your expectations. *(check yes or no)*

**Yes    No**

- |     |     |  |
|-----|-----|--|
| ___ | ___ | 1. Do you have a heart condition?  |
| ___ | ___ | 2. Have you ever experienced a stroke?   |
| ___ | ___ | 3. Do you have epilepsy?   |
| ___ | ___ | 4. Are you pregnant?   |
| ___ | ___ | 5. Do you have diabetes?   |
| ___ | ___ | 6. Do you have emphysema?  |
| ___ | ___ | 7. Do you feel pain in your chest when you engage in physical activity?  |
| ___ | ___ | 8. Do you have chronic bronchitis?   |
| ___ | ___ | 9. In the past month, have you had chest pain when you were not doing physical activity?   |
| ___ | ___ | 10. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?                         |
| ___ | ___ | 11. Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?           |
| ___ | ___ | 12. Has a physician ever told you or are you aware that you have high blood pressure?  |
| ___ | ___ | 13. Has anyone in your immediate family (parents/siblings) had a heart attack, stroke, or cardiovascular diseases before age 55? |
| ___ | ___ | 14. Has a physician ever told you or are you aware that you have a high cholesterol level?                                       |
| ___ | ___ | 15. Do you currently smoke?  |
| ___ | ___ | 16. Are you currently taking any medication(s)? Please list the medication(s) and the purpose?                                   |
| ___ | ___ | 17. Do you have any allergies to medication(s)? Please list the medication(s):   |
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How many times do you exercise per week? (check one)     1x    2x    3x    4x    5x    more

What is the duration (minutes) of your exercise session? (check one)    10    15    20    30    45    60

Please list all activities and sports you do regularly:

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How did you hear about us? \_\_\_\_\_

What are your specific fitness goals at Inursha Fitness? (check all that apply)

- Increase strength and endurance
- Improve cardiovascular fitness
- Reduce body fat
- Exercise regularly
- Sports conditioning
- Improve flexibility
- Improve muscle tone
- Increase muscle mass
- Injury rehabilitation
- Improve balance
- Other \_\_\_\_\_

What are your specific health goals at Inursha Fitness? (check all that apply)

- Reduce stress
- Control blood pressure
- Reduce back pain
- Increase health awareness
- Improve nutritional habits
- Control cholesterol
- Feel better overall
- Other \_\_\_\_\_

What motivated you to join Inursha Fitness? (check all that apply)

- Convenience/Location
- Membership promotion
- Peer support
- Medical referral
- Corporate membership

I have read, understood and completed this inquiry. Any questions I had were answered to my full satisfaction.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name