KENNEDY FITNESS, LLC

CLIENT MEDICAL HISTORY FORM

Medical History

1. Past and Present Personal Medical History (Please check all that apply):

____Heart or Artery Disease
____High Blood Pressure
____Abnormal electrocardiogram (ECG)
____Angina pectoris (chest pain)
____Abnormal chest X-ray
____Arteriosclerosis
____Anemia
____Stroke
____Asthma
____Shortness of Breath
____Lung/Pulmonary Disease
____Kidney/Liver Disease
____Gallbladder Disease
____Gastrointestinal Disease
____Neuromuscular Disease
____Ulcer (Stomach)
____Food Allergies
____Pregnant/lactating/trying to conceive
____Cancer
____Diabetes
____Epilepsy
____Arthritis Bursitis
____Rheumatism
____Hernia
____Recent Surgery
____Depression
____Psychological Problems
____Anorexia
____Bulimia
____Compulsive Overeating Disorder
____Chronic Pain
____Sacroiliac (hip) Problem
____Knee Problems
____Back Problems:
___cervical ___thoracic ___lumbar
____Other orthopedic or muscular problems

2. Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.)

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3. Have you ever had any surgeries? (If yes, please explain.) ________________________________

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4. Are you currently taking any medication? (If yes, indicate name of medication, dosage and reason for taking it.) ____

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5. Is there a family history of heart disease, hypertension, stroke, diabetes, heart failure, lung disease, or epilepsy? ____ Yes ____ No

If Yes, please provide information regarding who the relative is, the medical problem, and the age at onset or death: ____

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6. Please indicate any additional medical information that you think is important for us to know prior to fitness testing or exercise. ____

I certify that the above statements are true and correct. I understand that a Medical Release Form may be requested. If a form is requested, I will be unable to engage in physical activity with Kennedy Fitness, LLC until that form is received.

Client Signature: ________________________________ Date: ______________