Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENT/PAST HISTORY: Have you had OR do you presently have any of the following conditions? (Check if yes.)

|  |  |
| --- | --- |
| * Rheumatic fever * Recent operation * Edema (swelling of ankles) * High blood pressure * Injury to back or knees * Low blood pressure * Seizures * Lung disease * Palpitations or tachycardia (unusually strong or rapid heartbeat) * Intermittent claudication (calf cramping) * Pain, discomfort in the chest, neck, jaw, arms, or other areas with or without physical exertion * Known heart murmur * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Heart attack * Fainting or dizziness with or without physical exertion * Diabetes * High cholesterol * Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) nocturnal dyspnea (shortness of breath at night) * Shortness of breath at rest or with mild exertion * Chest pains * Unusual fatigue or shortness of breath with usual activities * Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body |

FAMILY HISTORY: Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

|  |  |
| --- | --- |
| * Heart arrhythmia * Heart attack * Heart operation * Congenital heart disease * Premature death before age 50 | * Significant disability secondary to a heart condition * High blood pressure * High cholesterol * Diabetes * Other major illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Explain checked items: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ACTIVITY HISTORY:

**1**. How were you referred to this program? (Please be specific.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**. Have you ever worked with a personal trainer before? Yes \_\_\_\_\_ No \_\_\_\_\_

**3**. Date of your last physical examination performed by a physician:

4. Do you participate in a regular exercise program at this time? Yes \_\_\_ No \_\_\_

**If yes, briefly describe**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5**. Can you currently walk 4 miles briskly without fatigue? Yes \_\_\_\_\_ No \_\_\_\_\_

**6**. Have you ever performed resistance training exercises in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

**7**. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes \_\_\_ No \_\_\_ **If yes, briefly describe**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8**. Do you smoke? Yes \_\_\_ No \_\_\_

**If yes, how much per day and what was your age when you started? Amount per day \_\_\_ Age \_\_\_\_**

**9**. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel about your nutritional habits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10**. List the medications you are presently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11**. List in order your personal health and fitness objectives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12**. Do you have an in-home gym or gym membership at a fitness facility? Yes \_\_\_\_\_ No\_\_\_\_\_

I have read, understood, and completed this questionnaire and attest that it is truthful and complete to the best of my knowledge. I understand that this information will be kept confidential. I am aware of the risks in observing or participating in any activities or exercises offered and sponsored by VS2 FITNESS. I understand that all exercises that I will execute and participate in are entirely at my own risk and perils. I assume complete responsibility and liability for those risks and for the injuries that may occur as a result of these risks, even if injuries occur in a manner that is not foreseeable at the time I submit this agreement. I realize that by voluntarily assuming the risks involved, I will be solely responsible for any loss or damage I sustain, including personal injuries to me or damage to my property. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CLIENT INITIALS**

Have you tested positive to COVID-19 in the past 14 days?

* Yes
* No

Are you currently awaiting the results of a Covid-19 Test?

* Yes
* No

Do you have a fever, or have you felt hot or feverish recently (14-21 days)?

* Yes
* No

Do you have a cough, shortness of breath or difficulties breathing? Sore throat? Runny nose?

* \Yes
* No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

* Yes
* No

Have you experienced any recent loss of taste or smell?

* Yes
* No

Have you been exposed to anyone who tested positive to Covid-19 within the past 14 days?

* Yes
* No

Have you traveled on an airplane or been on a cruise in the past 14 days?

* Yes
* No

**Client Initials:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF THE STATUS OF YOUR HEALTH CHANGES BEFORE YOUR VISIT, PLEASE EMAIL: VS2FITNESS@GMAIL.COM.**

* I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet but may still be highly contagious.
* I understand that the staff at VS2 FITNESS are symptom-free and, to the best of their knowledge, have not been exposed to the virus.
* In order to reduce the risk of spreading COVID-19 within this office, I have answered the following screening questions as truthfully as possible.