

**Be Fit Physical Therapy & Pilates, LTD.**  
**Health & Physical Activity History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**In case of emergency, whom may we contact?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

**Personal Physician:**

Name: \_\_\_\_\_ Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Were you referred by a physician to begin an exercise program? \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Have you ever had a maximal stress test? Yes \_\_\_\_\_ No \_\_\_\_\_ Date: \_\_\_\_\_

If you answered "Yes" to the above question, please bring test results.

**Program Goals:**

_____ Body fat loss	_____ Muscular endurance	_____ Stress relief
_____ Cardiovascular endurance	_____ Muscular strength	
_____ Flexibility	_____ Sports performance	

**Exercise History:**

Are you participating in a regular exercise program? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

**Tobacco History:**

Never \_\_\_\_\_ Occasionally \_\_\_\_\_ Daily \_\_\_\_\_ Packs/day \_\_\_\_\_ #years \_\_\_\_\_ Date Quit \_\_\_\_\_

**Nutrition:**

Are you currently dieting? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

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**Present Symptoms:** (within last 12 months)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chest pain/Angina   | <input type="checkbox"/> Nausea/Vomiting on exertion | <input type="checkbox"/> Back pain              |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough on exertion           | <input type="checkbox"/> Muscle pain            |
| <input type="checkbox"/> Lightheadedness     | <input type="checkbox"/> Swollen legs                | <input type="checkbox"/> Joint pain             |
| <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Swollen arms/Lymphedema     | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Leg pain                    |   |

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

**Medications:** (list dosages, if known)

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

**Medical History:** (Have you had or do you have any of the following?)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever            | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Congenital heart condition | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Lung disease               | <input type="checkbox"/> Parkinson's disease    |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Seizures/Epilepsy      |
| <input type="checkbox"/> Heart operations    | <input type="checkbox"/> Multiple Sclerosis         | <input type="checkbox"/> Low blood pressure     |
| <input type="checkbox"/> Chest pain/Angina   | <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Injuries               |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Other (please specify) |

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

**Recent Surgeries:** \_\_\_\_\_  
\_\_\_\_\_

**Family History:** (Do any blood relatives have or have they had any of the following?)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> High cholesterol           | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Congenital heart condition | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Other (please specify) |

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

I verify the information provided above to be true and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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WAIVER

By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise program. I fully understand that the program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and any resultant injury or mishap that may affect my well being or health in any way. I hold harmless of any responsibility, the instructor, facility or any persons involved with this program or testing procedure.

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Signature

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Date

INFORMED CONSENT

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise which can enhance the musculoskeletal and cardio-respiratory systems. In signing this document, I acknowledge being informed of the possible strenuous nature of the program and the potential for unusual, but possible, physiological results including, but not limited to, abnormal blood pressure, fainting, heart attack or death. By signing this document, I assume all risk for my health and well being and hold harmless of any responsibility, the instructor, facility or any persons involved with this program and testing procedures. I understand that questions about exercise procedures and recommendations are encouraged and welcomed.

I verify the information provided above to be true and accurate to the best of my knowledge.

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Signature

Date