Elite Health & Fitness Training, Inc.

CLIENT PORTFOLIO: Personal Fitness Training

Name: _____

Date: _____ Age: _____ DOB: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Personal Contact Information

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

May we call you at your place of work if you are not at home when we try to contact you? Yes No

May we call you on your cell phone if you are not at home/office when we try to contact you? Yes No

E-Mail (Please Print Clearly): _____

How often do you check your email? Daily Every couple days Weekly Rarely

Can we send you your monthly invoice via email rather than through US Mail? Yes No

Emergency Contact Information

Name: _____ Relation: _____

Telephone: (Day) _____ (Evening) _____

Family Physician Information

Name: _____ Telephone: _____

City/Town: _____ Fax: _____

Exercise History

How many times per week can you *realistically* exercise and for how long each session?

_____

What prior exercise experience do you have and how long ago was it?

_____

_____

Please list any physical recreational activities you are involved with: _____

_____

How did you find out about Elite Health & Fitness Training, Inc? _____

Medical History Questionnaire

Have you ever been told that you have/had any of the following medical conditions?

****Please check all that apply****

Cancer		Cirrhosis/Liver Disease	
Diabetes		Polio	
Hypoglycemia		Chronic Bronchitis	
Hypertension (High Blood Pressure)		Pneumonia	
Heart Disease		Migraine Headaches	
Angina		Anemia	
Stroke		Stomach Problems (Ulcers)	
Kidney Disease		Arthritis	
Kidney Stones		Gout	
Urinary Tract		Visual Problems	
Allergies		Hearing Problems	
Asthma		Seizures Disorder	
Rheumatic Fever		HIV/AIDS	
Hepatitis/Jaundice		Tuberculosis	
Osteoporosis		Neurological Condition(s)	
Vertigo/Balance Disorder		Sciatica/Radiculopathy/Back Pain	
Broken/Fractured Bone(s)		Soft Tissue Injury (i.e. Sprains/Strains)	

*If you have checked any of the above listed medical conditions that require additional explanation, please indicate that below:

_____

_____

If you are currently being treated for any medical conditions please list them here:

_____

Please list any and all operations you have had in your lifetime:

_____

Do you smoke? _____ How many packs per day & for how many years? _____

Occupation (This may be important information when designing ***your*** exercise program):

_____