

Health History Form

Please fill out this form and bring it to your meeting with Human Performance.

Today's Date: _____ Name: _____

Mailing Address: _____ City _____ Zip _____

Home Address: _____ Home Phone #: _____

Cell Phone#: _____ Emergency Contact# and name: _____

Best E-Mail: _____ Age: _____

Height: _____ Weight: _____ Sex: M or F Blood Pressure _____ Body-fat _____

Have you had your blood labs done recently? Circle One: Yes or No Last lab date: _____

Triglycerides _____ HDL _____ LDL _____ Cholesterol _____ Blood Sugar _____

Primary Doctor Name: _____ Phone: _____ City: _____

Current Dietary Supplements: _____

Have you had a personal trainer before? Circle One: Yes or No Explain: _____

Do you get massages? Circle One: Yes or No

Would you like to get massages after your workout? Circle One: Yes or No Explain: _____

Do you work with a chiropractor or acupuncturist? Circle One: Yes or No Explain: _____

Are you currently experiencing pain or tension in your bones, muscles, or joints? Circle One: Yes or No

Explain: _____

Do you have any illnesses or conditions? Circle One: Yes or No

Explain: _____

Are you currently taking any medications? Circle One: Yes or No

Explain: _____

Are you currently involved in an exercise program? Circle One: Yes or No

Time per workout: _____ Hours

Average number of days per week: _____ Days

Explain your current workout: _____

Are you interested in doing outdoor workouts with a trainer? Circle One: Yes or No

Types:

Canoeing

Cross Country Skiing

Road Biking

Rock Rappelling

Hiking

Scuba Diving

Ocean Kayaking

Swimming

Skiing

Tennis

Other: _____

Do you have any friends that would be interested in working out with you for indoor or outdoor workouts?

Circle One: Yes or No

Who: _____

Do you have any fitness or nutrition goals? Circle One: Yes or No

Explain your goals: _____

Briefly explain what you typically eat at home:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Briefly explain what you typically eat at restaurants:

Human Performance

Health History Form

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

How often do you eat out? _____

How often do you eat at home? _____

Do you cook for yourself? _____ Circle One: Yes or No Who: _____

How much alcohol do you drink per day? _____ ounces Type: _____

How much coffee do you drink per day? _____ ounces Type: _____

How much soda do you drink per day? _____ ounces Type: _____

How much juice do you drink per day? _____ ounces Type: _____

How much desert do you eat daily? _____ Type: _____

How much sleep do you get per night? _____ hours

Do you have problems sleeping? Circle One: Yes or No What causes your sleeping problems? Explain _____

What type of deodorant do you use? _____

What type of water do you drink? _____

Is your household water filtered? _____

Are you physically able to participate in a general exercise program? Choose One: Yes or No

How much time do you spend sitting per day? _____ hours

How much time do you spend standing or walking per day? _____ hours

Rate your physical health: Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

Rate your psychological stress levels: High _____ Medium _____ Low _____

How do you deal with psychological stress? Excellent _____ Very Good _____ Good _____ Fair _____ Poor _____

Do you meditate or pray? Circle One: Yes or No Explain: _____

What psychological and physiological factors inhibit you from obtaining your health goals? _____

Name the three most important things to you in your life? _____

What are your three greatest psychological strengths? _____

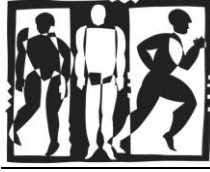
What are your three greatest psychological weaknesses? _____

What would you like to gain from this program? _____

Do you have any exercise equipment? Explain:

Any comments or questions?

HUMAN PERFORMANCE WAIVER



NAME

PHONE

ADDRESS

CITY

STATE & ZIP

I accept full responsibility for my use of any and all apparatus, appliances, facility privilege or service whatsoever, owned and operated by HUMAN PERFORMANCE at my own risk and shall hold this facility, its shareholders, directors, officers, employees, representatives, and agents harmless from any and all loss, claim injury, damage or liability sustained or incurred by me resulting therefrom.

Signature

Date

If under 18 years of age, signature of parent or guardian is required.

HUMAN PERFORMANCE MEDICAL INFORMATION RELEASE



AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/CLIENT HEALTH

I hereby give my permission to release to HUMAN PERFORMANCE any medical information pertinent to my exercise program.

Member Name (Please Print) _____

Doctor's Name (Please Print) _____

Medical Record # _____ Date of Birth _____

DURATION: This authorization shall become effective immediately and shall remain in effect until
Date: _____ or for 1 year from the date of signature.

PURPOSE: FITFIRST'S purpose in requesting this information is to ascertain the state of our member's health so that we may design and implement a safe and effective workout.

REDISCLASURE: I understand the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

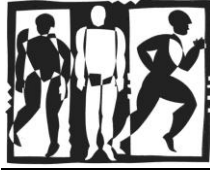
REVOICATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester of others have acted in reliance upon this Authorization.

RECORDS: Medical information and doctors recommendation. _____ (Initials)

To Disclose to
HUMAN PERFORMANCE
2225 BROWN STREET SUITE 106
Napa, CA. 94558

Patient's Signature _____ Date _____

HUMAN PERFORMANCE MEDICAL RELEASE FORM



TO BE COMPLETED BY FITFIRST

Dr's Name _____ Member Name _____

Fax Date _____ Appt. Date _____ Trainer _____

TO BE COMPLETED BY PHYSICIAN

I have evaluated _____ (Patient Name) on (Date) _____

And feel he/she can participate safely in an exercise program, taking into consideration the recommendations, limitations and special instructions listed below.

Recommendations: _____

Limitations: _____

Special Instructions: _____

Physician's Signature: _____

Please forward this form to:
HUMAN PERFORMANCE
2225 BROWN STREET SUITE 106
Napa, CA. 94558
Or
Fax To: 707-255-9991

