



GENERAL INFORMATION

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Mobile: _____ E-Mail: _____
DOB: _____ Age: _____ Gender: _____

EMERGENCY INFORMATION

Contact Name: _____ Relationship: _____
Contact's Tel: _____

PERSONAL MEDICAL HISTORY

Please indicate if you now have or have had any of these conditions:

General:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Chest Pain/Discomfort | <input type="checkbox"/> Irregular Heart Rhythm |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Respiratory Disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Other: _____ |

Musculoskeletal Problems:

- | | |
|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knee/Hip Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Muscular Weakness |
| <input type="checkbox"/> Former Injuries (Please list) | <input type="checkbox"/> Painful Joints |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Other: _____ |

Please list any medications that you are **currently** taking:

Do you currently smoke? Yes No

FAMILY MEDICAL HISTORY

Have any of the following conditions been present in a blood relative? Please indicate if any of your parents, grandparents, aunts, uncles, or siblings now have or have had any of these conditions:

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Surgeries | <input type="checkbox"/> Other: _____ |

PHYSICAL ACTIVITY HISTORY

Please indicate the type and amount of exercise or activity that you do regularly:

- | | |
|---|--|
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Running |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Bicycling | <input type="checkbox"/> Snow Boarding |
| <input type="checkbox"/> Dancing | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Hiking | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> House and/or Yard Work | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Martial Arts | <input type="checkbox"/> Weightlifting |
| <input type="checkbox"/> Pilates | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Racquetball | <input type="checkbox"/> Other: _____ |

INFORMED CONSENT & LIABILITY WAIVER RELEASE

I have been informed of associated risks with any exercise and it is my desire to participate. I have informed Ethan of any relevant information regarding my physical condition which may affect me during or following our sessions. Furthermore, I will inform Ethan of any change in my condition.

I agree that Ethan Carter is not responsible for any injuries sustained by me during my exercise sessions. I hereby release Ethan Carter and all parties involved from any responsibilities.

eSignature of Participant

Print Name

Date