KIRCHNER FITNESS

Health History Overview

Print a copy, fill out and give to Bob at first meeting.

Name: ..... Date: .....

Age: ..... Date of Birth: ..... Sex M/F .. Phone: .....

Height: ..... Weight: ..... Date of Last Physical: .....

Primary Physician's Name/Phone: .....

Emergency Contact: Name: ..... Phone: .....

Are you taking any medications, supplements or drugs? If so, please list medications, dose and reason:

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List any past injuries, surgeries, or areas of discomfort: .....

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Describe any past physical activities you have done or are doing regularly now: .....

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What are your personal exercise goals? Check all that apply.

☐ Weight loss/control ☐ Staying in shape ☐ Build Muscle ☐ Build strength

☐ Stress Reduction ☐ Cardiovascular conditioning ☐ Other

If other, please describe: .....

.....

What type of exercise interests you? ☐ Walking ☐ Jogging ☐ Strength training

☐ Stationary bike ☐ Elliptical ☐ Stair climber ☐ Other .....

Typical daily diet: *Breakfast*: .....

Lunch: ..... *Dinner*: .....

Additional information or comments before beginning your exercise program? .....

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Bob Kirchner
PERSONAL TRAINER & WELLNESS COACH
406-212-6693 · kirchnerfitness@gmail.com
kirchnerfitness.com