



Health History Information

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Day Phone: _____ Eve. Phone: _____ Mobile: _____

E-mail Address(es): _____

Occupation: _____ Company: _____

Sex: Male ___ Female ___ Height: ___ Weight: ___ Date of Birth: ___ / ___ / ___

3 favorite hobbies/interests: _____

If Applicable: Anniversary Date: _____ Children's Name(s) & Age(s): _____

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?

Name: _____ Phone: _____

Relationship: _____

Physician's name: _____ Phone: _____

HOW DID YOU HEAR ABOUT SERIOUS STRENGTH?

Friend _____ Brochure _____

Spouse _____ Television _____

Physician _____ Radio _____

Newspaper/Magazine _____ Internet _____

The Slow Burn Fitness Revolution (2003) _____ Other _____

CURRENT PHYSICAL ACTIVITY

TYPE	HOW OFTEN
_____	_____
_____	_____
_____	_____
_____	_____

1. Conditions

PLEASE CIRCLE ONE

If YES, supply as much detail as possible.

Do you have any history of heart problems?	No	Yes	_____
Do you have a current heart condition?	No	Yes	_____
Have you ever had a heart attack or stroke?	No	Yes	_____
Have you ever experienced chest pains?	No	Yes	_____
Do you have high or low blood pressure?	No	Yes	_____
Do you have arthritis?	No	Yes	_____
Do you have high cholesterol?	No	Yes	_____
Are you pregnant now or within the last 3 months?	No	Yes	_____
Any medical procedures within the last 12 months?	No	Yes	_____
Do you experience dizziness or fainting?	No	Yes	_____
Do you have asthma or any respiratory problems?	No	Yes	_____
Do you have Diabetes or a thyroid condition?	No	Yes	_____
Do you have or have you had a hernia of any kind?	No	Yes	_____
Are you taking any medications?	No	Yes	_____
Do you have a chronic illness or condition?	No	Yes	_____
Are you prone to headaches?	No	Yes	_____
Other?	No	Yes	_____

2. Injuries

PLEASE CIRCLE ONE

If YES, supply as much detail as possible.

Have you ever had any lower back problems?	No	Yes	_____
Do you have any neck problems?	No	Yes	_____

Do you have or have you had any other joint or muscle problems? (e.g. fibromyalgia) No Yes

3. Other

PLEASE CIRCLE ONE
If YES, supply as much detail as possible.

Are you currently under the care of a physician for any reason at all? No Yes

Do you smoke cigarettes, cigars, or other? No Yes

Do you use drugs and/or alcohol? No Yes

Are you taking any dietary supplements? No Yes

Does your doctor know that you are beginning a new exercise program? No Yes

If yes to the above question, does he/she object? No Yes

Do you know of any other physical or mental condition that you have or have had that could be aggravated, worsened, exacerbated, inflamed, etc., by exercising or exerting yourself?

Please read this waiver in its entirety before signing. Do not sign this waiver if any part of it is not clearly understood:

I certify that the above statements are true and complete. Furthermore, I have had a medical examination within the last year that verified that I am in good health and able to participate in a strenuous physical conditioning program. I release Serious Strength, Inc., from all claims, injuries, damages, illnesses, actions or causes of action, and from all acts of active or passive negligence on the part of the company, corporation, club, its owners, solvents, agents, trainers, instructors, independent contractors or employees. I acknowledge that Serious Strength, Inc. will rely on my statements and representations.

Signature: _____

Date: _____

Witness: _____

Date: _____