


SLS FITNESS
STRENGTH AND CONDITIONING CENTER
Health Screening and Questionnaire

Date: _____

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone: _____

E-mail Address _____

I do not wish to be on email list at this time

DOB _____

Physician's Name _____

Phone _____

Person to contact in case of emergency: _____

Phone _____

Describe your physical activity _____

Are you taking any medications? _____

Do you have any health considerations? _____

Do you have, or have you had in the past? Please **Write YES or NO** to each

Heart Attack?

High Blood Pressure?

Chronic Illness?

Difficulty Exercising?

Recent Surgeries?

Pregnancy?

Muscle, Joint, or Back Aches or Pains?

Diabetes?

Thyroid?

Cigarette Smoking?

Increase Blood Cholesterol?

History of Heart problems?

What are your exercise goals? _____

How did you hear about us? _____