INSTINCTIVEFITNESS

Do you have any medical conditions that may prevent you from exercising? YES ( ) NO ( )

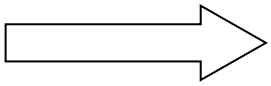
Please tell me about it_____

Access your health needs by marking all true statements with a **Y**es or **N**o

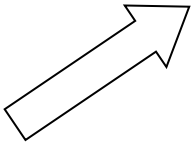
History

you have had:

___ heart attack
___ heart surgery
___ pacemaker
___ heart valve disease
___ heart failure
___ heart transplantation
___ congenital heart disease



If you marked ***ANY*** of the options in this section as ***TRUE*** your Quality of Life Specialist will show what I need to do before getting toward your NEW "Quality of Life Plan"



Symptoms

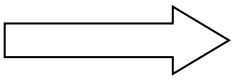
___ you experience chest discomfort with exertion
___ you experience unreasonable breathlessness
___ you experience dizziness, fainting, blackouts
___ you take heart medications

Other Health Issues

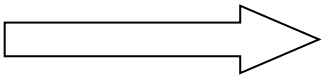
___ you have musculoskeletal problems
___ you are concerned about the safety of the exercise
___ you take prescription medications
___ you are pregnant or may be pregnant

Cardiovascular Risk Factors

___ you are a man older than 45
___ you are a women older than 55 or you are postmenopausal or have had a hysterectomy
___ you are a smoker or gave up in the past 6 months
___ your blood pressure is greater than 140/90 mmHg
___ you don't know your blood pressure
___ you take blood pressure medication
___ your blood cholesterol level is > 240 mg/ml
___ you don't know your blood cholesterol level
___ you have a close blood relative who has a heart attack before age 55
___ you are diabetic or take medicine to control your blood sugar
___ you are physically inactive i.e. you get less than 30 minutes of exercise on at least three days of the week
___ you have epilepsy
___ you have Asthma
___ Only one of the above is true
or none of the above is true



If you marked ***Two or more*** of the options in this section as ***TRUE*** your Fitness Professional will show what we need to do before getting toward your NEW "Life and Goals"



Awesome...you are a picture of health and I can get on with moving towards your goals immediately!

Do you have any joint problems, aches or pains I can aim to improve for you? YES ( ) NO ( )

Please describe

_____

Do you take any prescription medication, pills, tablets or supplements? YES ( ) NO ( )

Please describe

_____