

# Form 5-2

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	Yes	No
Musculoskeletal Limitations of Movement		
Difficulty Breathing/Shortness of Breath		
Arthritis, Rheumatism		
Knee Problems		
A chronic, recurrent or morning cough		
Any episode of coughing up blood		
Increased anxiety or depression		
Swollen, stiff or painful joints		
Back Pain (Herniated or ruptured Disc)		
Shoulder Pain		
Surgery		

**IMPORTANT:** If you answered **Yes** to any of the previous questions, contact your physician as soon as possible.

Your Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_

I certify to the best of my knowledge the above information is correct and complete. I also understand that, \_\_\_\_\_ assumes no responsibility for any illness, accident or injury I may incur from the use of the programs, services or facilities. All individuals are strongly encouraged to consult with a physician before entering a non-medically supervised exercise program.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of IFPA Certified Trainer \_\_\_\_\_ Date \_\_\_\_\_

***This form may be used by current IFPA Certified Instructors only. Use of this form by anyone not IFPA Certified or an Instructor who has expired is prohibited. No one may change the wording of this form without express written consent of IFPA***