

Fitness Assessment Personal Training Initial Consultation

Name (Please print): _____

Date: _____

Lifestyle & Goals

What is your primary fitness goal?

- | | |
|---|---|
| <input type="checkbox"/> Overall Fitness
<input type="checkbox"/> Lose Weight/Body Fat
<input type="checkbox"/> Gain Weight/Muscle
<input type="checkbox"/> Increase Muscular Strength
<input type="checkbox"/> Increase Cardiovascular Endurance
<input type="checkbox"/> Improve Sport Performance | <input type="checkbox"/> Body Building (competitive)
<input type="checkbox"/> Improve Balance
<input type="checkbox"/> Decrease Stress
<input type="checkbox"/> Manage Chronic Health Condition _____
<input type="checkbox"/> Other: _____ |
|---|---|

YES NO Are you currently involved in a regular aerobic exercise program such as walking, jogging, cycling, swimming, step aerobics, etc?

YES NO Are you currently participating in weight training?

YES NO Do you perform stretching exercises on a regular basis?

How often does your schedule allow you to exercise or come to the gym?

_____ days per week

How many minutes per day can you devote to your workout?

_____ minutes per workout

What is your current occupation? _____

Does it require any of the following:

- _____ Extended periods of sitting
_____ Extended periods of standing
_____ Extended periods of repetitive movements.

Please describe _____

Functional Capacity

Do you have difficulty with any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Picking up a small child
<input type="checkbox"/> Carrying a 10lb bag of groceries
<input type="checkbox"/> Performing household chores (e.g., vacuuming, mopping, washing windows)
<input type="checkbox"/> Climbing a flight of stairs
<input type="checkbox"/> Walking without assistance (cane, walker, etc.)
<input type="checkbox"/> Opening a jar of food | <input type="checkbox"/> Getting in and out of the bathtub
<input type="checkbox"/> Rising from a sofa or low chair without using arms for assistance
<input type="checkbox"/> Placing or retrieving objects from overhead
<input type="checkbox"/> Tendency towards muscle strains and/or sprains: _____
<input type="checkbox"/> Other _____ |
|--|--|

Medical History

Have you ever been diagnosed with any of the following conditions? Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> History of heart problems, chest pain or stroke (including uncontrolled rhythm) | <input type="checkbox"/> Tobacco Use _____ |
| <input type="checkbox"/> Uncontrolled blood pressure (high or low) | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Lung conditions (i.e. asthma/pneumonia) | <input type="checkbox"/> Neuromuscular diseases (i.e. MS, ALS, MD) |
| <input type="checkbox"/> COPD (i.e. emphysema/chronic bronchitis) | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Infectious disease (i.e. hepatitis, AIDS, STD) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Seizure activity (i.e. epilepsy) | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Severe hydrophobia (fear of water) | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental disorders (i.e. clinical depression, PTSD) |
| | <input type="checkbox"/> Currently have draining or infected wound/rash |
| | <input type="checkbox"/> Currently pregnant or post partum |
| | <input type="checkbox"/> Other: _____ |

Are you currently taking any medications? Please describe:

Prescription: _____

Non-Prescription: _____

Vitamins/Supplements: _____

Do you currently have any pain or injuries (ankle, neck, back, hip, shoulder, etc.)? Please explain: _____

Have you ever had any surgeries? Please list below: (use back of page if needed)

<u>Approximate date</u>	<u>Injury/Condition/Surgery</u>
_____	_____
_____	_____
_____	_____