

The Fit Effect, LLC

Personal Training

Effective Fitness through Motivation, Communication and Perspiration!

Fitness Assessment Health / Medical Status

Personal Data

Date: _____

Name: _____

Occupation: _____ Male: _____ Female: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Evening Phone: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Dr. Name: _____ Phone: _____

Birth Date: _____ Age: _____ Height _____ (Inches)

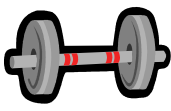
Present / Past History

Have you had OR do you presently have any of the following conditions? (Check if yes.)

- | | |
|---|--|
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Recent Operation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Injury to Back or Knees |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis or Joint pain that is aggravated by exercise | |

If other, please explain:





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Activity History

1. Are you currently exercising? (Please be specific, how long, how many days a week, what equipment?)

2. Have you ever performed resistance training exercises in the past? Yes_____ No_____

3. What have you done in the past to promote your personal health and fitness?

4. List in order your personal health and fitness goals. Examples: lose weight, general fitness, reduce stress, muscular strength, improve diet, boost in energy, sports specific, lower cholesterol, look and feel better, muscular size.

5. What areas of your body do you want to improve the most?

6. Females; are you pregnant? Yes_____ No_____

7. How many days a week are you planning to commit to work out, at what time? On a scale of 1-10 (1 being the lowest and 10 being highest), what is your level of commitment?

8. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes_____ No_____ If yes, briefly describe:

9. Do you follow or have you recently followed any specific dietary intake plan? In general how do you feel about your nutritional habits? How many meals a day do you eat including snacks?

10. List the medications you are presently taking.

I certify that the above statements are true and correct. I understand that a Doctor's note may be requested. If a note is requested, I should not proceed with this workout until the note is received.

Participants Signature:_____Date:_____

