



Personal Training & Fitness Center

FITNESS ASSESSMENT /HEALTH STATUS

Name _____ Date _____

Occupation _____ Male _____ Female _____

Address _____ State _____ Zip _____

E-mail _____ Phone _____

Emergency Contact _____ Phone _____

Birth Date _____ Age _____ Height _____ Weight _____

Present/Past History

I. RISK FACTORS

- ____ 1. Have any of your parents or siblings had a heart attack, bypass surgery, angioplasty or sudden death prior to the age of 55(male relative) or 65(female relative)?
- ____ 2. Have you smoked cigarettes in the past 6 months?
- ____ 3. Do you take blood pressure medication?
- ____ 4. Is your usual blood pressure 140/90 or more?
- ____ 5. Is your Fasting Glucose level >100?(if you know it)
- ____ 6. BMI (>30?) _____ waist girth(>100cm?) (We will measure these during assessment)
- ____ 7. Do you get at least 30min of moderate physical activity most days of the week?

II. SYMPTOMS

- ____ 1. Do you ever have pain or discomfort in your chest or surrounding areas (ie, ischemia)?
- ____ 2. Do you ever feel faint or dizzy (other than when sitting up rapidly)?
- ____ 3. Do you find it difficult to breathe when you are lying down or sleeping?
- ____ 4. Do your ankles ever become swollen (other than after a long period of standing)?
- ____ 5. Do you ever have heart palpitations or unusual period of rapid heart rate?
- ____ 6. Do you ever experience pain in your legs (ie. intermittent claudication)?
- ____ 7. Has a physician ever said you have a heart murmur? (Has he said it is OK and safe to exercise?)
- ____ 8. Do you feel unusually fatigued or find it difficult to breath with usual activities?



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III. OTHER

- ___ 1. How old are you? (Men >45, women >55 are at moderate risk)
- ___ 2. Do you have any of the following diseases? Circle if "yes"
 Heart disease Peripheral vascular disease Thyroid disorder Asthma Diabetes
 COPD(emphysema, chronic bronchitis) Liver disease Renal disease Cystic fibrosis
- ___ 3. Do you have any bone or joint problems, such as arthritis or a past injury, that might get worse with exercise?
- ___ 4. Do you have a cold, flu or any other infection?
- ___ 5. Females: Are you pregnant?
- ___ 6. Do you have any other problems that might make it difficult for you to do strenuous exercise?

ACTIVITY HISTORY/GOALS

- 1. Are you currently exercising? ___ how long? ___ months. How many days a week? _____.
What equipment? _____
- 2. Have you ever performed resistance training in the past? Yes ___ No ___
- 3. List your personal, health and fitness goals. Examples: lose weight, general fitness, muscular strength, improve diet, stop smoking, sports specific, muscular size, improve health, look and feel better. _____
- 4. What areas of your body do you want to improve the most? _____
- 5. Have you ever worked with a personal trainer before? Yes ___ No ___
- 6. How many days a week are you planning to work out? On a scale of 1-10 (1 being the lowest & 10 being highest), what is your level of commitment? _____
- 7. Do you or have you followed any specific dietary plan? (ie. Weight watchers, Atkins, Sugar Busters.....) How do you feel about your nutritional habits? _____
- 8. List any Medications you are currently taking _____

I certify that the above statements are true. I understand that a Doctor's note may be requested and this workout should not proceed until it is obtained.

Participants Signature _____ Date _____