Personal Information

General Information

First Name: ___________________________ Last Name: _____________________

Address: _____________________________ City, State, Zip: _________________

Phone #: _____________________ Email: _________________________

Sex: M/F Age: ___ Birth date: __/___/____

Physician's Name: ____________________ Physician's Phone: _______________

Emergency Contact: __________________ Phone #: _____________________

Health History

Please read the following list and answer honestly to all of the questions by placing a *'YES'* or *'NO'* on each line. Please note that if the line is followed by an '*', a Medical Clearance Form is required before your exercise testing and program can begin. All information is given on a voluntary basis.

Cardiovascular Risk Assessment

Do you:

____Have a history of Heart disease?*

____Have high cholesterol?*

____Have high blood pressure?*

____Have a family history of heart disease?

____Have Diabetes?*

____Smoke Cigarettes?
(or quit within the last 6 months)

Other Conditions

Do you have:

____Epilepsy or Seizures?*

____Breathing or Lung Problems
(such as asthma or Chronic Obstructive Pulmonary Disease)?*

____Recently released from physical therapy?*
Reason: ______________________________

____Recent or present hernia?*

____Recently (past 6 months) or presently pregnant?*

____Recent Surgery (past 6 months)?*
If yes, what type?_____________________

____Any other limitations?
Explain: ________________________

Please list all medications that you are currently taking & what you are taking them for:

____

____

Signature: ____________________________ Trainer: _______________________

Date: ________________

Please allow trainer to examine your answers to the previous questions before continuing! Administer medical clearance form if necessary.

Personal Information

Exercise History

1. Are you currently involved in a regular exercise program? Yes No

2. Do you regularly lift weights? Yes No

3. Do you consider yourself:
   Highly active   Moderately active   Lightly active   Sedentary

4. Would you characterize your life as:
   Highly stressful   Moderately stressful   Low in stress

5. Which of the following describes your knowledge of exercise and fitness:
   Very knowledgeable   Knowledgeable   Limited/No knowledge

6. Briefly explain your involvement in physical activity in the past
   6 months ____
   12 months ____
   5 years ____
   Lifetime ____

7. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value & 5 the highest).
   Circle the number that applies the most to your current fitness level.

When you exercise, how important is competition	1	2	3	4	5
Cardiovascular capacity	1	2	3	4	5
Muscular capacity	1	2	3	4	5
Flexibility	1	2	3	4	5
Total Fitness Level	1	2	3	4	5

8. How much time are you willing to devote to an exercise program?
   minutes/day __________   days/week ___________

9. What type of exercise do you enjoy or would like to try?

___ Walking and/or jogging
___ Weight training (machines)
___ Swimming
___ Cycling (outdoors)
___ Free weights
___ Stationary bikes
___ Racquetball
___ Tennis
___ Yoga
___Aerobic class
___ Hiking/rock climbing
___ Team sports
___ Rowing
___ Martial Arts
___ Stretching

Personal Information

Goals & Expectations

Goals should be SMART: Specific, Measurable, Attainable, Realistic & Time-Bound

Rank your goals:

Extremely Important		Somewhat Important		Not at all Important
1	2	3	4	5

___ improve cardiovascular fitness

___ weight loss

___ improve performance for a specific sport/event

___ decrease stress

___ other: ___________________________________

___ increase strength

___ increase energy level

___ improve flexibility

___ enjoyment

Short-term goals: (first 4 weeks)

____

____

____

Long-term goals: (first 6 months to a year)

____

____

____

Lifetime goals:

____

____

____

**Please feel free to change and update your goals as much as you would like.
Your trainer will help you set S.M.A.R.T. goals.**