



FITNESS HEALTH ASSESSMENT FORM

Name: _____ Gender: M F Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell/Work Phone:(_____) _____

In case of emergency, contact:

Name: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

HEALTH HISTORY

PLEASE FILL OUT COMPLETELY ALL QUESTION BELOW. If you Answered YES to any QUESTION BELOW, YOU NEED A WRITTEN MEDICAL RELEASE FROM YOUR DOCTOR!!

Do you have or have you ever had any of the following?

Do you take any MEDICATIONS?

HEART

Heart Attack YES NO
Heart Disease YES NO
Stroke YES NO
Abnormal EKG YES NO

For the Heart YES NO
For High Blood Pressure YES NO
High Cholesterol YES NO

OTHER

Diabetes YES NO

IMPORTANT INFORMATION

Responding to this Health Questionnaire is purely voluntary and you do not have to share your responses with the staff of the Fitness Services. However, please recognize that individuals with coronary risk factors or other medically significant risk factors, run a greater chance of cardiovascular incident or increased risk of injury during physical activity. Although you are solely responsible for determining if you are physically fit for any and all fitness activities, it is always advisable, especially if you are pregnant, suffer from an underlying medical condition, take medication, smoke cigarettes, have a family history of coronary disease, or have recently suffered an illness, injury or impairment, to consult a physician before undertaking any physical activity.

Please recognize the staff of the Fitness Services are not medical practitioners. However, any voluntary communication of the above requested information to our staff may assist the staff in identifying adverse signs and symptoms that might compromise your well-being and which should be evaluated and assessed by qualified medical personnel.

I HAVE READ AND UNDERSTAND THE PRECEDING STATEMENT

Signature Required

Date



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Occupational Questions

1. What is your current occupation?

2. Does your occupation require extended periods of sitting? Yes No

3. Do you sit for more than 8 hours a day? Yes No

4. Do you use a computer or sit a desk more than 8 hours a day? Yes No

5. Does your occupation require extended periods of repetitive movements?

Yes No

If yes, please explain _____

6. Does your occupation require you to wear shoes with a heel (dress shoes)?

Yes No

7. Does your occupation cause you anxiety or mental stress? Yes No

Medical Questions

1. Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)?

Yes _____ No

2. Have you ever had any surgeries?

Yes _____ No

3. Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes?

Yes _____ No

4. Are you currently taking any prescription or over the counter medication(s)?

Yes _____ No



General Questions

1. Do you have any children?
 Yes How many? _____ Ages _____ No
2. Are you currently active? Yes No
3. Do you partake in any recreational activities (golf, tennis, skiing, etc.)?
 Yes _____ No
4. Do you have any hobbies (reading, gardening, working on cars, surfing the web)?
 Yes _____ No
5. Do you smoke? If so, how many per day?
 Yes _____ No
6. Do you drink caffeine? If so, how many drinks per day?
 Yes _____ No
7. Do you drink alcohol? If so, how many drinks per day?
 Yes _____ No
8. Have you ever worked with a trainer? If so, where and for how long?
 Yes _____ No

Nutritional Questions

1. Typically how many meals do you eat per day? _____
2. Do you know approximately how many calories you consume per day? _____
3. Are you currently taking a multivitamin or other dietary supplements? _____

4. Typically how many meals do you eat outside the home per week? _____
5. On a scale of 1-10 how would you describe your current diet (1 being poor – 10 being healthy)? _____



Goal Questions

6. What do you feel is/was your ideal weight? _____

7. How much weight would you like to lose (if applicable)? _____

8. What goals are you trying to achieve and why? _____

9. Is there anything that has prevented you from achieving this goal in the past? _____

10. Do you have a specific time frame for achieving this goal? _____

11. How many days a week can you dedicate to exercising with a trainer? _____