Today's Date: ________________

Fitness Profile

Name: ________________________________

Address: ________________________________
City: __________________ State:____ Zip:________

Home Phone: ( ) ________________
Work Phone: ( ) ________________
Cell Phone: ( ) ________________
E-Mail Address: ________________

Age:____________ Birthdate:________________
Occupation:________________________________

Height:________ Weight:________ Sex:________
Last Physical Exam: ________________

In Case of Emergency Contact: ____________________ Phone:____________________

Referred by: ______Yellow pages ______Article/Ad in local publication
______Trainer/Client ______________________________(please fill-in name)
______Doctor/Health professional ______________________________(please fill-in name)

Your fitness trainer wants to provide the highest quality service possible.
The following will be used to design your personal fitness program.

1. **MEDICAL HISTORY**

These conditions affect your ability to exercise, please check the items which apply to you.

______High Blood Pressure -Specify______________________________
______Heart Ailment -Specify______________________________
______Family History of Heart Disease -Specify______________________________
______Stroke or Family History of Stroke -Specify______________________________
______Heart Palpitations
______Chest Pains
______Dizzy spells or Fainting
______Difficulty Breathing or ______ Asthma
______Hay Fever or ______ Allergies -Specify______________________________
______Shortness of Breath from Mild Exertion
______Epilepsy
______Diabetes -Specify Type I or Type II ______________________________
______Hypoglycemia
______Thyroid Problems
______Polio
______Cancer
______High Cholesterol -Specify: Triglycerides level ________ Glucose level ________
______Currently under a Doctor's Care -Specify ______________________________
______Hospitalized for Illness, Injury or Surgery - Specify______________________________
______Currently on medication – List any you are taking now ______________________________
______Other______________________________

Do you have or have you had back problems? ______ If yes, please explain problem:________________

____

____

Do you have or have you had problems in any muscles, joints, ligaments or tendons, (arthritis, calcium deposits, torn muscles, torn cartilage, tendonitis, nerve injury, bone fractures, bone dislocations, hernias, tennis elbow, etc.)? If yes, please explain the problem and when it last occurred.

____
____
____

Please explain any other medical problems or accidents you have had (i.e. car, sports, a fall, etc.)

____
____
____

2. **PROFILE**

Do you smoke? ________If yes, How many cigarettes a day? ________________________

How old were you when you started?____ If you have quit smoking, when did you quit?________

Do you often feel anxious, tense, or under pressure or stress? (circle one)

almost never occasionally frequently nearly constantly

How would you describe your eating habits? ______________________________
____
____

Do you often eat FEWER than 3 meals a day? If so, which meal do you skip? (Circle one)

Breakfast Lunch Dinner

How many alcoholic beverages do you usually drink per week (circle one)

0 1-2 3-4 > 4

3. **ACTIVITY PROFILE**

1) How many hours of exercise do you regularly do each week? ____________________

2) Please List:

ACTIVITY	FREQUENCY	SINCE WHEN?

Have you ever participated in any of the above activities on a competitive or professional level?

____

3) Are you aware of your working heart rate and if so what range do you work in? ________

4) GOALS: Please list 5 goals

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________

To the best of my knowledge, all of the above statements are complete and true.

Signature:______________________________ Date:________________