



FITNESS ASSESSMENT & WAIVER

Client Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home): (_____) _____ (Work): (_____) _____

Other phone numbers (state type): (_____) _____

Occupation: _____ How long? _____

Email address: _____

Emergency Contact: _____ Phone: (_____) _____

Physician's Name: _____ Phone: (_____) _____

Are you currently under a physician's care? ___No ___Yes If yes, please explain why:

MAJOR CORONARY RISK FACTORS

YES NO

1. History of high blood pressure (>140/90) or on blood pressure medications.		
2. Elevated total cholesterol (>200mg/dl), LDL (>130mg/dl) or HDL(<40mg/dl) or on lipid lowering medications.		
3. Cigarette smoking or have quit within the last 6 months.		
4. Abnormal resting EKG		
5. Family History. Please circle: heart attack, stroke, peripheral vascular disease, congenital heart disease or sudden death prior to 55 years old for male or 65 years old for female immediate relative. Please circle: mother, father, grandparent, uncle/aunt, sibling		
6. Fasting blood sugar (>100 mg/dl)		
7. Diabetes mellitus: type I or type II (please circle)		

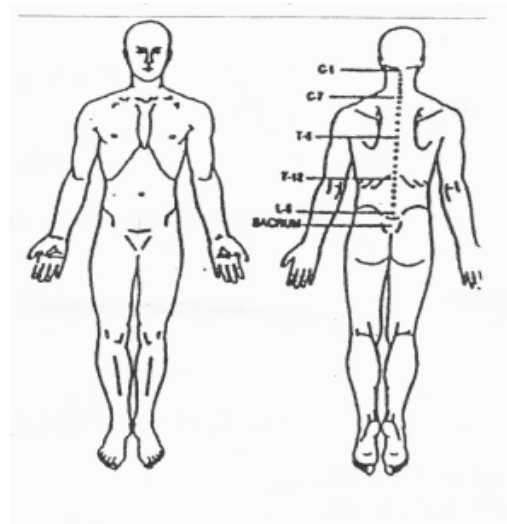
MEDICAL HISTORY (Please check if applicable)

YES NO

	YES	NO
1. Heart attack, coronary bypass, or cardiac surgery. Circle & date:		
2. Chest discomfort especially with exertion		
3. Extra, skipped, or rapid heartbeats/palpitations		
4. Heart murmurs, clicks, or unusual cardiac findings		
5. Stroke		
6. Cancer: Please define		
7. Pulmonary disease, including asthma, emphysema and bronchitis		
8. Unusual shortness of breath		
9. Peripheral vascular disease		
10. Phlebitis, emboli		
11. Kidney disease		
12. Liver disease		
13. Rheumatic fever		
14. Light-headedness, dizziness or fainting (loss of consciousness)		
15. Hernia or any condition that may be aggravated by lifting weights		
16. Ankle swelling		
17. Emotional disorder		
18. Obesity (BMI>30 kg/m ² or waist measurement >39 inches for men / waist measurement >35 for women)		
19. Orthopedic problems: arthritis, on-going bone, muscle or joint problem that might be made worse with exercise. Please define:		
20. Osteoporosis or Osteopenia, please circle.		
21. Back or spinal (vertebrae) problems		
22. Drug allergies: If yes, please explain:		
23. Recent illness, hospitalization or surgical procedures		
24. Other: Please list		

Please list any current medications and their purpose:

Please indicate with an “X” on any area where you are feeling discomfort or pain:



DO YOU CONSUME (Please check if applicable)

YES NO

1. Caffeine, including soda and energy drinks (list number & type per day):		
2. Alcoholic beverages (list number per day):		
3. Tobacco (list amount per day):		
4. Other non-prescription or over the counter drugs (please list):		
5. Supplements (vitamin, minerals, herbs, fish oil, etc.) (please list):		

1. Are you currently exercising regularly? ___Yes ___No
2. Type of Activity: _____
3. Frequency/Week: _____ Duration (minutes): _____
Intensity: Maximum heart rate while exercising: _____
Subjective assessment: Hard (%)_____ Medium (%)____ Light (%) _____
4. What is your Height? _____ Your current weight? _____
5. What is your goal weight? _____
6. Do you know your % body fat? _____
7. Is there a physical reason not mentioned here as to why you should not follow an exercise program even if you wanted to? ___Yes ___No If so, please explain.

8. Have you had any dramatic changes in your weight? ___Yes ___No If so, please explain.

9. How many hours of sleep do you get per day?
10. How much water do you drink per day?
11. Do you follow any special diet at the present time? ___ Yes ___ No If so, what type?

12. How many days per week can you commit to your fitness program?
13. Do you have a physician's approval to participate in a vigorous exercise program?
___Yes ___ No If yes, please provide a copy.
If no, are you willing to get one? ___Yes ___No If no, please explain why.

14. Do you like/dislike exercising? (Circle one) Why?

15. List the types of exercise you like.

16. What are your reasons for starting an exercise program?

17. List your past and present hobbies and leisure activities.

WHAT ARE YOUR PARTICULAR FITNESS GOALS?

- | | |
|--|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> General Conditioning |
| <input type="checkbox"/> Injury Rehabilitation | <input type="checkbox"/> Strength Conditioning |
| <input type="checkbox"/> Sports Conditioning | <input type="checkbox"/> Stress Relief |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Body Building |
| <input type="checkbox"/> Endurance/Stamina | <input type="checkbox"/> Other (please explain) |

Additional Comments:

WAIVER

Please read carefully and sign.

I hereby acknowledge that all information included herein is correct and I understand that there are risks involved in participating in any exercise program. I certify that I am in good physical condition and including, but not limited to, physical strain and exertion, I assume all such risks by requesting entry into the exercise program.

I am aware that medical or any other kind of insurance is not provided.

I intend to be legally bound, do hereby for myself, my heirs, executors and administrators, waive and release all rights and claims for damages I might accrue against any and all instructors of exercise classes, their successors, representatives and assigns any and all injuries suffered by me while traveling to and from and participating in exercise classes, instruction and fitness tests.

Signature: _____ Date: _____

Parent/guardian signature (if applicable) Date: _____