Date ______ / ______ / ______

1) Referred? Yes ◯ No ◯ By Whom? ______________________________

2) Name: ______________________________ **3)** Age: __________ **4)** Height: __________

5) Permanent Home Address: ______________________________ **6)** Weight: __________

7) Home Phone: ______________ **8)** Work Phone: ______________ **9)** Pager: ______________ **10)** Cell: ______________

11) E-mail Address: ______________ **12)** Primary Physician: ______________________ **13)** Phone: __________

14) Emergency Contact: ____________________ **15)** Phone: ______________ **16)** Profession: ______________

17) Relationship ______________ Marital Status __________ Spouse/Partners Name ______________________

18) Sport Performance/Enhancement Supplements, Vitamins, Health Herbs, Weight Loss/Gain Pills, Powders, Liquids, and solids taken:

____

19) Medications

____

20) What are your two top fitness goals, and why?

____

21) On a scale from 1-5 what is your daily stress level, and why? (1 being lowest) __________

22) How much time do you set aside for social activities or recreation? ______________________________

____

23) How many hours per week on the average do you work? ______________________________

24) Do you smoke? How much per day? Yes ◯ No ◯ ______________________________

25) Current workout program: ______________________________

26) Workout Frequency/week Minutes Per Session
Description

27) Level of activity now:
Sedentary ◯ Semi-Active ◯ Active ◯ Extremely Active ◯

28) How often do you consume alcohol? ______________________________

29) Fitness Interests: ______________________________

____

30) Former activities performed: ______________________________

31) Nutrition - rated on scale of 1 - 5 (1 being poor): ________

32) Are you willing to change your eating habits? ______________________________

Medical History

33) Last Physical/Check-up: ______________________________

34) Is MD aware of desire to become more physically active? Yes ◯ No ◯

35) History of heart disease, chest pain or discomfort, heart murmur or arrhythmia? Yes ◯ No ◯

36) History of coronary artery disease (CAD), Stroke? Yes ◯ No ◯

37) Family history of heart disease (Parents, Grandparents, Siblings)? Yes ◯ ◯ No
If yes, specify age at time of event or diagnosis: ______________________________

____

38) High blood pressure or taking Anti-hypertension medications? Yes ◯ No ◯
If on medication, specify drug and type of drug: ______________________________

____

39) Borderline or high serum blood cholesterol (>200 MG/DL)? Yes ◯ No ◯

40) History of breathing or lung problems (asthma or chronic bronchitis)? Yes ◯ No ◯

41) Severe shortness of breath during daily activities? Yes ◯ No ◯

42) Any sleeping disorders or trouble having a good night's rest? Yes ◯ No ◯

43) Muscle, Joint, and/or back pain or disorder of arthritis or prior injury? Yes ◯ No ◯
Specify details, such as what might aggravate the condition, which side of body, pain scale, causes, etc.

44) History of hernia or any condition that lifting weights could aggravate? Yes ◯ No ◯

45) Surgery or hospitalization within the last 12 months? (If yes, specify incident). Yes ◯ No ◯

46) Surgery or hospitalization planned (in or out patient procedure) within next 30 days? (If yes, please specify) Yes ◯ No ◯

47) Excessive accumulation of body fat? Yes ◯ No ◯

48) History of diabetes (Non-insulin Dependent Diabetes, Insulin Dependent Diabetes)? Thyroid condition (hypo/hyperthyroid)
Seizure activity? Yes ◯ No ◯ ______________________________

____

49) Pregnancy now or within the last 3 months? Yes ◯ No ◯ If pregnant, when are you expecting? ______ / ______ / ______

50) Any difficulty with exertion or advice from MD not to exercise or limit activities? Yes ◯ No ◯

51) Any chronic or prolonged illness or condition? Yes ◯ No ◯

____

52) Any other condition not addressed above that may be aggravated by an increase in physical activity? Yes ◯ No ◯
Specify: ______________________________

____

____