

# Fitness Profile

Today's Date:

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Name: \_\_\_\_\_ Phone: (AM) \_\_\_\_\_ (PM) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Last Physical Exam: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

**I want to provide the highest quality of service possible. The following will be used to design your personal fitness program.**

## Medical History

These conditions affect your ability to exercise. Please check the items that apply to you:

- High Blood Pressure-Specify—
- Heart Disease-Specify—
- Heart Palpitations
- Dizzy Spells or Fainting
- Shortness of Breath from Mild Exertion
- Diabetes-Specif- Type 1 or Type 2—
- Thyroid Problems
- Stroke or Family History of Stroke-Specify—
- High Cholesterol-Specify-Triglycerides Level—
- Hay Fever or Allergies-Specify—
- Currently Under a Doctor's Care-Specify—
- Heart Ailment-Specify—
- Cancer-Specify—
- Chest Pains
- Difficulty Breathing or Asthma-Specify—
- Epilepsy
- Hypoglycemia
- Polio
- Hospitalized for Illness, Injury, or Surgery-Specify—
- Currently on Medication-Specify—
- Other

Do you have or have you had back or neck problems? If yes, please explain with date of occurrence:

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Current Level of Pain on a scale of 1-10 (1 being low and 10 high): \_\_\_\_\_

Do you or have you had other musculo-skeletal problems (ankles, knees, hips, pelvis, shoulders, elbows, wrists, any injury to nerves, muscles, tendons, or ligaments)? If yes, please explain with date of occurrence:

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Current Level of Pain on a scale of 1-10 (1 being low and 10 high): \_\_\_\_\_

Please explain any other medical condition you have or have had that we should know about (arthritis, thyroid, car accident, fall, clinical depression, elective surgical procedure, etc):

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### **Lifestyle**

Do you often feel anxious, tense, under pressure or stressed? (Circle one)

Almost Never    Occasionally    Frequently    All the Time

How would you describe your eating habits?

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

none    1-2    3-4    4+

### **Activity Profile**

How many hours of exercise do you regularly do each week?

Please list below all of your current physical activities (walking, swimming, surfing, weight program, etc):

Activity	Frequency	Length of Time	Intensity
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### **Personal Fitness Goals**

Please list two goals on which you would like to focus:

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

Signature:

Date

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