Fitness Assessment
Personal Training Initial Consultation

Name (Please print):_____ Date: _____
Phone #: _____ Date of Birth: _____

Lifestyle & Goals

What is your primary fitness goal?

- ☐ Overall Fitness
- ☐ Lose Weight/Body Fat
- ☐ Gain Weight/Muscle
- ☐ Increase Muscular Strength
- ☐ Increase Cardiovascular Endurance
- ☐ Improve Sport Performance
- ☐ Body Building (competitive)
- ☐ Improve Balance
- ☐ Decrease Stress
- ☐ Manage Chronic Health Condition_____
- ☐ Other:_____

☐ YES ☐ NO Are you currently involved in a regular aerobic exercise program such as walking, jogging, cycling, swimming, step aerobics, etc?

☐ YES ☐ NO Are you currently participating in weight training?

☐ YES ☐ NO Do you perform stretching exercises on a regular basis?

How often does your schedule allow you to exercise or come to the gym?
____days per week

How many minutes per day can you devote to your workout?
_____minutes per workout

What is your current occupation? _____
Does it require any of the following:
____Extended periods of sitting
____Extended periods of standing
____Extended periods of repetitive movements.
Please describe_____

Functional Capacity

Do you have difficulty with any of the following?

- ☐ Picking up a small child
- ☐ Carrying a 10lb bag of groceries
- ☐ Performing household chores (e.g., vacuuming, mopping, washing windows)
- ☐ Climbing a flight of stairs
- ☐ Walking without assistance (cane, walker, etc.)
- ☐ Opening a jar of food
- ☐ Getting in and out of the bathtub
- ☐ Rising from a sofa or low chair without using arms for assistance
- ☐ Placing or retrieving objects from overhead
- ☐ Tendency towards muscle strains and/or sprains: _____
- ☐ Other _____
  _____

Medical History

Have you ever been diagnosed with any of the following conditions? Please check all that apply:

- ☐ History of heart problems, chest pain or stroke (including uncontrolled rhythm)
- ☐ Uncontrolled blood pressure (high or low)
- ☐ High Cholesterol
- ☐ Circulation problems
- ☐ Lung conditions (i.e. asthma/pneumonia
- ☐ COPD (i.e. emphysema/chronic bronchitis)
- ☐ Infectious disease (i.e. hepatitis, AIDS, STD)
- ☐ Anemia
- ☐ Seizure activity (i.e. epilepsy)
- ☐ Severe hydrophobia (fear of water)
- ☐ Cancer
- ☐ Tobacco Use_____
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Obesity
- ☐ Neuromuscular diseases (i.e. MS, ALS, MD)
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Stroke or TIA
- ☐ Kidney Disease
- ☐ Hernia
- ☐ Mental disorders (i.e. clinical depression, PTSD)
- ☐ Currently have draining or infected wound/rash
- ☐ Currently pregnant or post partum
- ☐ Other:_____

Are you currently taking any medications? Please describe:
Prescription: _____
_____
_____

Non-Prescription: _____
_____
_____

Vitamins/Supplements:_____
_____
_____

Have you ever had any pain or injuries (ankle, neck, back, hip, shoulder, etc.)? Please explain: _____
_____

Have you ever had any surgeries? Please list below: (use back of page if needed)

Approximate date Injury/Condition/Surgery
_____
_____
_____
_____