The FIRM U

A CLINICAL FITNESS STUDIO

FITNESS ASSESSMENT / HEALTH STATUS

Name _____ Date_____

Occupation _____ Male _____ Female _____

Address _____ City _____ State _____ Zip _____

E-mail_____ Phone _____

Facebook ID _____ How did you hear about us? _____

Emergency Contact _____ Phone _____

Birth Date _____ Age _____ Height _____ Weight _____

PERSONAL HEALTH HISTORY

	YES	NO
RISK FACTORS		
Have any of your parents or siblings had a heart attack, bypass surgery, angioplasty or sudden death prior to the age of 55 (male relative) or 65 (female relative)		
Have you smoked cigarettes in the past 6 months?		
Do you take blood pressure medication?		
Is your usual blood pressure 140/90 or more?		
Do you get at least 30 min of moderate physical activity most days of the week?		
SYMPTOMS		
Do you ever have pain or discomfort in your chest or surrounding areas (i.e., ischemia)?		
Do you ever feel faint or dizzy (other than when sitting up rapidly)?		
Do you find it difficult to breathe when you are lying down or sleeping?		
Do your ankles ever become swollen (other than after a long period of standing)?		
Do you ever have heart palpitations or unusual period of rapid heart rate?		
Do you ever experience pain in your legs (i.e. intermittent claudication)?		
Has a physician ever said you have a heart murmur?		
If you answered YES to the above question, has your doctor said it's safe for you to exercise?		
Do you feel unusually fatigued or find it difficult to breath with usual activities?		

YES	NO

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OTHER		
Do you have any of the following diseases? If yes, please circle those that apply to you: Heart Disease ◆ Peripheral Vascular Disease ◆ Thyroid Disorder ◆ Asthma ◆ Diabetes ◆ COPD (Emphysema, Chronic Bronchitis) ◆ Liver Disease ◆ Renal Disease ◆ Cystic		
Do you have any bone or joint problems, such as arthritis or a past injury, that might worsen with exercise?		
Do you have a cold, flu or any other infection?		
For females: Are you pregnant?		
Do you have any other problems that might make it difficult for you to do strenuous exercise?		
ACTIVITY HISTORY/GOALS		
Are you currently exercising? If yes, how long? _____ How many days a week? _____		
Have you ever performed resistance training in the past?		
Have you ever worked with a personal trainer before?		
Please circle your personal health and fitness goals. Lose Weight ◆ Look and Feel Better ◆ General Fitness ◆ Muscular Strength ◆ Muscular Size ◆ Improve Diet ◆ Improve Health ◆ Stop Smoking ◆ Sports Specific ◆ Other (please describe)		
Do you or have you followed any specific dietary plan? If so, please circle the one(s) applicable to you Weight Watchers ◆ Atkins ◆ Sugar Buster ◆ Other (please describe)		
How do you feel about your nutritional habits?		
What area(s) of your body do you want to improve the most?		
How many days a week are you planning to work out (please circle)? 1 2 3 4 5 6 7		
What time of day are you planning to work out (please circle)? Morning ◆ Afternoon ◆ Evening		
On a scale of 1-10 (1 being lowest & 10 being highest), what is your commitment level?		
Please list any medications you are currently taking		

I certify that the above statements are true. I understand that a Doctor's note may be requested, and this workout should not proceed until it is obtained. In volunteering for this program, I agree to assume responsibility for these risks and waive any possibility for personal damage. I also agree that to my knowledge, I have no limiting physical conditions or disability that would preclude an exercise program. By signing below, I accept full responsibility to my health and well-being AND I acknowledge and understand that no responsibility is assumed by the leaders of the program, including but not limited to The Fit Effect, L.L.C.; dba The FIRM U and all independent trainers and employees.

Participant's Signature _____ **Date** _____