

Personal Trainer Long Island Relies On



Client Health and Physical Activity Worksheet

Name: _____ Trainer: _____
 Address: _____ Age: _____ Birthdate: _____
 _____ Sex: _____ Height: _____
 Email: _____ Weight: _____
 Phone: Home (____) _____ Business (____) _____
 Physician's Name: _____ Phone: _____
 Address: _____
 Emergency Contact-Name/Relationship: _____ Phone: _____
 Salesperson: _____ # of Sessions purchased: _____
 Type of payment: Visa/MC Check Cash
 Amount of sale: \$ _____ Payment received (circle): YES NO

1. Which days and times are best for you?

	Time
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

Start date: _____
 How often: _____
 Forms completed:
 Health History Yes No
 Participant Release Yes No
 Billing Agreement Yes No
 Doctor's Release Yes No

2. Please check if applicable

	<u>Client</u>		<u>Family</u>		<u>If Yes, Describe</u>
	YES	NO	YES	NO	
Diabetes	___	___	___	___	_____
High Blood Pressure	___	___	___	___	_____
High Cholesterol	___	___	___	___	_____
Smoke or use tobacco products	___	___	___	___	_____
Angina/Chest Pain	___	___	___	___	_____
Heart Murmur	___	___	___	___	_____
Irregular Heart Beats	___	___	___	___	_____
Abnormal Electrocardiogram	___	___	___	___	_____
Rheumatic Fever	___	___	___	___	_____
Thrombophlebitis	___	___	___	___	_____
Respiratory Infections	___	___	___	___	_____
Asthma	___	___	___	___	_____
Embolism	___	___	___	___	_____
Aneurysm	___	___	___	___	_____
Stroke	___	___	___	___	_____
Valve Disease	___	___	___	___	_____
Heart Attack	___	___	___	___	_____

3. Do you have any of the following conditions that may limit your physical activity? (check all that apply)

Ankle/Foot Injury Bone Fracture Shoulder/Clavicle Injury Arthritis
 Low Back Pain Wrist/Hand Injury Arm/Elbow Injury Knee/Thigh Injury
 Hip/Pelvic Injury Calcium Deposits Nerve Damage Tennis Elbow
 Upper Back Injury Head/Neck Injury Other

If other, please explain: _____

4. Has your physician ever advised you against exercise? Yes No
 5. Are you presently receiving physical therapy? Yes No

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6. **Are you presently taking any medications?**
 Yes No If **yes**, please list names and dosages of each: _____

7. **Are you involved in an exercise program at the present time?** Yes No
 If **yes**, please describe the program: _____
8. **How would you rate the amount of physical activity at work?**
 Very Little Little Moderate Active Very Active
9. **How would you rate the stress level of your job?**
 Little Moderate Stressful
10. **When exercising, including climbing stairs, do you ever experience any of the following?** (check all that apply)
 Chest Pains Shortness of Breath Pressure over the Heart A Tired-Out Feeling
 Leg Aches Dizziness
11. **Have you ever had a stress test?** Yes No
 If so, date of most recent test: _____
 Results: Normal Abnormal
12. **What was your weight one year ago?** _____ **Five years ago?** _____ **At age:** _____
13. **Do you follow any special diet at the present time?** Yes No
If so, what type?
 Low Cholesterol/Low Fat Low Salt Reduced Calorie Liquid Diet Other
 If **other**, please specify: _____
14. **What are your personal exercise program goals?**
 Weight Control/Loss Staying in Shape Stress Reduction Increasing Strength
 Cardiovascular Conditioning Other
 If **other**, please specify: _____
15. **What equipment do you presently have?**

16. **Any additional information or comments before beginning your exercise program?**

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