FITBODY STUDIO
FITNESS + SPA

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TODAY'S DATE

ASSESSMENT **SHEET**

Name____ Birthdate_____/_____/_____

Address____

City______________________________________ State_______ Zip ______________

Home phone__________________________ Work phone ________________________

Cell phone__________________ Cell carrier to receive appointment reminders via text:__________

Email ____

Contact person in case of emergency:________________________ Phone______________

How did you hear about us?____

____

FITNESS**PROFILE**

1 Current weight_______________________ Current height_______________________

2 What is your desired fitness goal?____

____

3 How long have you been at your current fitness level? ______________________________

4 Describe what you would like to accomplish with your fitness during the next:

One session:____

Six months: ____

One year:____

5 Have you had any bad experiences or any negative feelings towards any physical activity program? ☐ yes ☐ no

If yes, explain?____

____

6 Do you begin exercise programs, but find yourself unable to stick with them? ☐ yes ☐ no If yes, explain why?

____

____

7 What is your current activity level?

☐ None (0 hours) ☐ Light (1-3 hours/week) ☐ Moderate (4-6 hours/week) ☐ Heavy (7-8 hours/week)

8 What are your current cardiovascular training activities?_____________________________

____

9 What are your current strength training activities? ________________________________

10 What physical activities do you enjoy? (check all that apply)

☐ Jogging ☐ Aerobics Dance ☐ Cycling ☐ Team Sports
☐ Walking ☐ Racquet Sports ☐ Hiking ☐ Resistance Training
☐ Swimming ☐ Boxing ☐ Pilates ☐ Yoga
☐ Other ____

ASSESSMENT **SHEET**

11 What are your reasons for not exercising? ____________________

12 Do you now, or have you had in the past:

- History of heart problems, chest pain or stroke ☐ yes ☐ no
- Increased blood pressure ☐ yes ☐ no
- Any Chronic illness or condition ☐ yes ☐ no
- Difficulty with physical exercise ☐ yes ☐ no
- Advice from physician not to exercise ☐ yes ☐ no
- Recent surgery (last 12 months) ☐ yes ☐ no
- Pregnancy (now or within last 3 months ☐ yes ☐ no
- History of breathing or lung problems ☐ yes ☐ no
- Muscle, joint or back disorder, or any previous injury or pains still affecting you ☐ yes ☐ no
- Diabetes or thyroid condition ☐ yes ☐ no
- Cigarette smoking habit ☐ yes ☐ no
- More than 20% over ideal body weight ☐ yes ☐ no
- Increased blood cholesterol ☐ yes ☐ no
- History of heart problems in immediate family ☐ yes ☐ no
- Hernia, or any condition that may be aggravated by lifting weights ☐ yes ☐ no

13 Please explain any "yes" answers: ____________________

____

____

____

14 Do you take any medications? If yes, what kind of medication: ____________________

____

15 Any other health risk you are aware of: ____________________

____

LIFE**STYLE**

1 Which days of the week and at what time can you work out?

- ☐ Monday - Times of day ____________
- ☐ Tuesday - Times of day ____________
- ☐ Wednesday - Times of day ____________
- ☐ Thursday - Times of day ____________
- ☐ Friday - Times of day ____________
- ☐ Saturday - Times of day ____________
- ☐ Sunday - Times of day ____________

2 What is your present occupation? ____________________

3 Does your occupation require much activity? ☐ yes ☐ no

4 What are your usual leisure activities? ____________________

5 What type of things make you feel stressed? ____________________

6 How do you deal with your stress normally? ____________________

7 Do you feel any family, friends or co-workers have negative feelings toward your efforts at physical activity? ______

____

8 Is your significant other or a close friend involved in any regular physical activity? ☐ yes ☐ no