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