Name _____ Date _____

Address _____

Telephone (Home) _____ (Work) _____ (Cell)_____

E-mail Address _____

Age _____ Height _____ Weight _____

Emergency Contact: _____ Relation _____ Telephone _____

Prior to participation in the Individual Fitness Solutions Ltd. fitness evaluation you must complete this form in full. The medical and fitness data collected within will help in assessing your fitness capacity, thereby aiding in the development of a personal fitness program. If you have any questions please do not hesitate to ask your trainer for an explanation.

Who are your primary- and secondary-care providers? (Family physician, internist, cardiologist, chiropractor, etc.) Please include full name, address, phone number and reason for seeing the provider.

| Name | Address & Phone | Care Provided |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# MEDICAL HISTORY

Check if you had or are presently suffering from any of the following health problems:

| | | | | | |
|---|---|---|---|---|---|
| Irregular heart beats | _____ | Emphysema | _____ | Muscle/tendon problems | _____ |
| Rapid heart beat | _____ | Asthma | _____ | Liver disease | _____ |
| Palpitations | _____ | Diabetes | _____ | Soft tissue injury | _____ |
| High blood pressure | _____ | Kidney disorder | _____ | Arthritis | _____ |
| Low blood pressure | _____ | Hernia | _____ | Bone/joint problems | _____ |
| Heart disease | _____ | Epilepsy | _____ | Upper back/neck pain | _____ |
| Angina (chest pain) | _____ | Allergies | _____ | Lower back/hip pain | _____ |
| Stroke | _____ | Fainting | _____ | Anemia | _____ |
| Peripheral vasc. disease | _____ | Tuberculosis | _____ | Vericose veins | _____ |

If you checked any of the preceding conditions, please explain: _____

_____

_____

_____

1. When was the date of your last physical exam by a physician?_____

2. Have you been under the care of a physician for any reason during the past year? Yes _____ No _____
   If yes, please explain:_____

3. Have you ever had a maximal stress test? Yes _____ No _____
   If yes, Where: _____ When: _____ Physician's Name: _____

4. Have you had any surgery? Yes _____ No _____
   If yes, please explain: _____

5. Are you presently taking any medications? Yes _____ No _____
   If yes, please list name, dosage, frequency taken, and reason for taking:

| Name | Dosage | Frequency | Reason For Taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

6. Do you feel that you are constantly under stress, anxious or nervous? Yes _____ No _____
   If yes, please explain: _____ How do you cope with it? _____

7. When you perform daily activity (climbing stairs, walking, gardening) do you experience any of the following?
   shortness of breath _____ dizziness _____ headaches _____ cramps _____ discomfort in joints/muscles _____

8. Is there a good physical reason not mentioned above why you should not follow an activity program? Yes _____ No _____
   If yes, please explain: _____

9. Do you frequently suffer pain in your chest? Yes _____ No _____
   If yes, please explain: _____

10. Are you over age 65 and not accustomed to vigorous exercise? Yes _____ No _____

# FAMILY HISTORY OF DISEASE

Has anyone in your family (M, F, GM, GF, A, U, B, S) suffered from any of the following conditions:

| | | | |
|---|---|---|---|
| Heart disease | _____ | Diabetes | _____ |
| Stroke | _____ | Cancer | _____ |
| High blood pressure | _____ | Kidney disease | _____ |
| High cholesterol/triglycerides | _____ | Arthritis | _____ |
| Nervous disorder | _____ | Other | _____ |

# NUTRITIONAL HABITS AND WEIGHT MANAGEMENT

Maximum Weight Attained _____ Minimal Weight Attained During Adulthood _____

1. Do you eat the following meals on a regular basis?

   (please check) Breakfast _____ Lunch _____ Dinner _____ Snacks _____

2. Do you diet? Yes _____ No _____

   If yes, Why? Weight loss _____ Medical reasons _____ Weight Gain_____ Other_____

3. Are you presently on any specific diet, eating program, or have you used diet pills/shakes? Yes _____ No _____
   If yes, please explain: _____

4. Have you consulted with a physician regarding diet and exercise? If yes, please describe the recommendations:
   _____
   _____

5. What, if any, changes would you like to make to your current eating habits? _____

6. Have you had any unexplained weight change, not due to dieting? Yes _____ Explain:_____ No _____

7. Have you had your cholesterol & triglyceride levels checked? Yes _____ No _____
   Date: _____ Results: Cholesterol: _____ Triglycerides: _____

# SMOKING AND ALCOHOL

1. Do you smoke:

| | | | | | |
|---|---|---|---|---|---|
| Cigarettes? | Yes _____ | No _____ | Number per day _____ | Number of years _____ |
| Cigars? | Yes _____ | No _____ | Number per day _____ | Number of years _____ |
| Pipes? | Yes _____ | No _____ | Number per day _____ | Number of years _____ |

2. If you stopped smoking, how long ago did you quit? _____

3. Do you consume alcoholic beverages? Yes _____ No _____

If yes: Beer ___ Wine ___ Liquor ___ How Many: Amount Daily_____ Amount Weekly_____ Amount Monthly_____

# PHYSICAL ACTIVITY HISTORY

1. Do you participate in regular exercise? Yes _____ No _____

   If yes, how many days per week? _____ Duration of exercise per day? _____

2. How long have you been exercising regularly? _____ months _____ years

3. Please rate your exercise participation for each age range through to present age (1= rarely; 10= a lot)
   15-20_____ 21-30_____ 31-40_____ 41-50_____ 51-60_____ 60+_____

4. Were you a high school or college athlete? Please list sports and positions:_____
   _____

5. Do you own any exercise equipment? Please list. _____

6. What type of exercise/activities do you take part in:

| | Exercise/Activity | Time spent in activity | Frequency per week |
|---|---|---|---|
| A. | _____ | _____ | _____ |
| B. | _____ | _____ | _____ |
| C. | _____ | _____ | _____ |

7. If you were previously on an exercise program, what was the reason for discontinuing it? _____

8. Do you have any negative feelings or have you had any bad experience with exercise programs, sports, or personal training?

   If yes, Please explain: _____

9. Rate yourself on a scale of 1 to 10 (1 indicating the lowest value and 10 the highest).

   Characterize your present athletic ability:
   1 2 3 4 5 6 7 8 9 10

   When you exercise, how important is competition?
   1 2 3 4 5 6 7 8 9 10

   Characterize your present cardiovascular endurance:
   1 2 3 4 5 6 7 8 9 10

   Characterize your present muscular strength:
   1 2 3 4 5 6 7 8 9 10

   Characterize your overall flexibility level:
   1 2 3 4 5 6 7 8 9 10

   Rate your perceived exertion for your current exercise program:
   1 2 3 4 5 6 7 8 9 10

10. Do you start exercise programs and then find you are unable to stick with them? Yes _____ No _____

    If yes, indicate the reason why _____

11. What types of exercise/ activities interest you?

| | | |
|---|---|---|
| ____Walking | ____Stationary biking | ____Jogging |
| ____Rowing | ____Swimming | ____Tennis |
| ____Cycling | ____Racquetball | ____Hiking |
| ____Dance exercise | ____Rollerblading | ____Stretching |
| ____Weight training | ____Mountain biking | ____Other aerobic training _____ |

# GOALS

1. Rank each item that relates to you and the level of importance in reaching your health/fitness goals. Use the following scale to rate each goal separately.

Not Important 1 2 3 4 5 Somewhat Important 6 7 8 9 10 Very Important

| | | |
|---|---|---|
| _____Improve cardiovascular fitness | _____Feel better mentally | _____Body-fat weight loss |
| _____Decrease back pain | _____Reshape/tone muscles | _____Improve flexibility |
| _____Improve athletic performance | _____Increase strength | _____Decrease stress |
| _____Increase energy level | _____Decrease cholesterol | _____General fitness |
| _____Stop smoking | _____Improve eating habits | |

2. Of these goals (or others not listed above) list your top 5, and how close or far (with an X) you are from reaching them right now.

| Your goals | Far Halfway Done |
|---|---|
| A._____ | _____ |
| B._____ | _____ |
| C._____ | _____ |
| D._____ | _____ |
| E._____ | _____ |

3. Please list two specific short-term health, fitness, or exercise related goals associated with your interest in a personal trainer:
   A._____

   B._____

4. Please list two specific long-term health, fitness, or exercise related goals associated with your interest in a personal trainer:
   A._____

   B._____

5. By how much would you like to change your current weight? Lose(-)_____ pounds Gain(+)_____pounds

6. Over what time frame would you like to make this change? _____number of months _____number of years

7. What would you perceive as challenging when you are exercising? How would you know that each exercise session is a success? (Exhausted, invigorated, a little sweaty, a lot sweaty, muscle soreness etc.) _____

8. What specific body parts would you like to work on? _____

9. Please include any additional comments or concerns you may have. _____

# CLIENT PROFILE

Age _____ Birth Date _____ Height _____

_____ **STOP HERE** _____

Today's Date_____

1. Resting Heart Rate _____
2. Resting Blood Pressure _____
3. Measurements: Shoulders _____ Chest _____ Waist _____ Hips _____ Thigh_____ Calf _____ Arm _____
1. Body Composition:

- BIA: Adult _____ Child _____ Athlete _____ Body Fat % _____ Weight _____
- Skin fold Measurements: Triceps _____ Biceps _____ Subscap _____ Ilium _____ Thigh _____ Abdomen _____
  Chest _____ Axilla _____ **Total** _____ Body Fat % _____ Lean body Mass % _____

# FITNESS TEST

- AEROBIC CAPACITY
  1. 3 Minute Step Test: 1 min. post HR _____
  2. Bruce Submaximal Treadmill Test: HR #1 _____ HR #2 _____
     Speed _____ Speed _____
     Gradient _____ Gradient _____
  3. Ebbeling Submax Treadmill Test: HR _____ Speed _____
  4. Balke Submax Treadmill Test: HR _____ Speed _____ Gradient _____

- MUSCULAR ENDURANCE
  1. Bench Press Test: Repetitions _____
  2. Push Up Test: Repetitions _____
  3. One Minute Timed Sit Up Test: Repetitions _____

- MUSCULAR STRENGTH
  1. Raw Upper Lift Exercise _____ Weight _____ Repetitions ____
  2. Raw Lower Lift Exercise _____ Weight _____ Repetitions____

- FLEXIBILITY
  1. Sit-And-Reach Test: Distance 1._____ 2._____ 3._____

# WAIVER AND RELEASE OF ALL CLAIMS

The CLIENT acknowledges that any program of fitness exercise involves a risk of injury. The CLIENT acknowledges that Individual Fitness Solutions Ltd. or its staff members are not nor do they claim to be medical doctors, and therefore, cannot take responsibility for any injury or illness related to personal fitness training.

The CLIENT represents that he/she has been recently examined by a medical doctor and been found able to undertake a program of exercise, and has made full disclosure of any injury or illness both past and present.

For and in consideration of the design of an exercise program for CLIENT by _____ (TRAINER) and/or Individual Fitness Solutions Ltd., CLIENT agrees:

1. That any exercise program shall be undertaken by CLIENT at his/her sole risk; and

2. That CLIENT is responsible for notifying TRAINER of any fitness exercise that causes any discomfort or pain; and

3. That it is the decision of CLIENT whether or not he/she will continue the exercise fitness program in the event of injury or illness; and

4. That TRAINER and/or Individual Fitness Solutions Ltd. shall not be liable to CLIENT, nor any other person, for any claims or causes of action whatsoever arising out of or connected with the services of TRAINER and/or Individual Fitness Solutions Ltd.; and

5. That CLIENT hereby releases and discharges TRAINER and/or Individual Fitness Solutions Ltd. from any such claims or actions.

_____ _____

(CLIENT signature) (Date)

( Parent signature if child is under 18 years of age)

# CANCELLATION POLICY

I understand that a fitness training session is one hour in duration from the scheduled appointment time, and that any tardiness will be considered time towards my one hour session unless otherwise noted herein. I understand that any fitness training session not canceled within 12 hours of the scheduled appointment time will be considered one fitness training session when making payments. I understand that ten sessions must be used within 120 days from the date of purchase unless otherwise noted herein.

_____ _____

Signature Date

# Individual Fitness Solutions Fitness Assessment Preparation

In order to assure that the results of your fitness assessment are as accurate as possible, please review the following guidelines. Your assessment will be given on the assumption that you have followed these recommendations.

1. Wear loose fitting clothes (jogging attire, shorts, athletic shoes, etc.)
2. Avoid eating or drinking 3 hours before your assessment (for best results on body composition tests)
3. Avoid alcohol, tobacco, and coffee for at least 3 hours before your assessment.
4. Avoid exercising on the same day as your assessment. Exercise will elevate your blood pressure and heart rate- invalidating these measures.
5. Try to get a good night's sleep the night before your assessment.
6. Please inform your trainer prior to the assessment if you are suffering from any acute respiratory infection, related condition, or any condition that may affect your test performance.
7. If you have been given a medical questionnaire and/or fitness assessment consent form, please have them completed when you arrive.

Your fitness assessment will consist of measurement of one or more aspects of your health and fitness. It may include your weight, cardiovascular condition (resting and exercise heart rate and performance), body composition, musculoskeletal condition, blood pressure, and body size (circumferences). The objective of your first assessment is to give you a baseline from which to measure your performance and to design the most appropriate exercise program for your current fitness level. Subsequent assessments will provide milestones to help you evaluate your progress.

## GOOD LUCK!

Trainers Name:
Assessment Date: