



# Health & Fitness Orientation

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Date/Time: \_\_\_\_\_

Personal Trainer: \_\_\_\_\_

## Personal Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Phone: (Eve) \_\_\_\_\_ (Day) \_\_\_\_\_ Email: \_\_\_\_\_

Gender (check one): Male  Female  Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Person to contact in case of an emergency: Name \_\_\_\_\_ Phone \_\_\_\_\_

## Goal Exploration:

What is your primary reason for joining the center? \_\_\_\_\_

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## How do you envision your success with this goal in...

30 days \_\_\_\_\_

90 days \_\_\_\_\_

6 months \_\_\_\_\_

1 year \_\_\_\_\_

Have you succeeded in reaching this goal before on your own?  Yes  No.

If yes, what strategies helped you towards this goal? \_\_\_\_\_

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If no, what obstacles (personal or professional) got in the way of achieving your goal? \_\_\_\_\_

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What changes or adjustments have you made to ensure that these same obstacles will not get in the way this time? \_\_\_\_\_

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How do you hope your membership in the fitness center will help you achieve your goal? \_\_\_\_\_

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## Lifestyle Habits Review:

What regular activities do you do now? \_\_\_\_\_

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How often? \_\_\_\_\_

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What are your best days to workout (check all that apply):

Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.  Sun.

Early Morning  Mid-morning  Noon  Mid-afternoon  Evening



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## Exercise History (please answer all questions):

- Yes  No 1. Has your doctor ever said you have heart trouble?
- Yes  No 2. Do you frequently have pains in your heart or chest?
- Yes  No 3. Do you often feel faint or have spells of dizziness?
- Yes  No 4. Has a doctor ever said your blood pressure was too high?
- Yes  No 5. Has your doctor ever told you that you have a bone or joint problems such as arthritis, which has been aggravated by exercise or might be made worse with exercise?
- Yes  No 6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?
- Yes  No 7. Are you over the age 65?
- Yes  No 8. Are unaccustomed to vigorous exercise?

Notes: \_\_\_\_\_

Physician's Release Form Required?  Yes  No (This is to be filled out by your trainer.)

## Health History (please answer all questions):

Have you ever or do you currently have the following:

### Orthopedic (Injury To or Pain In):

- |  |               |  |            |
|--|---------------|--|------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck or Spine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Knees      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Shoulders     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ankles     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Elbows        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lower Back |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Wrists        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hips          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scoliosis  |

Explain: \_\_\_\_\_

### Cardiovascular Risk:

- |  |                                 |  |                      |
|--|---------------------------------|--|----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure             | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cigarette Smoking               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Mellitus    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pain           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedentary Lifestyle  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heart Rate |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Family History of Heart Disease |  |                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Surgery                   |  |                      |

Explain: \_\_\_\_\_

Notes: \_\_\_\_\_

### Other Conditions:

- |  |                  |  |                 |
|--|------------------|--|-----------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent Illness  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Problems    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pregnancy        |  |                 |

Surgeries (Date): \_\_\_\_\_

Date of last Physical: \_\_\_\_\_

Medications: \_\_\_\_\_

Any Other Medical Conditions: \_\_\_\_\_

Physician's Release Form Obtained: \_\_\_\_\_ Date: \_\_\_\_\_





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NAME: \_\_\_\_\_

APPOINTMENT DATE/TIME: \_\_\_\_\_

