Name		Date	

This is your comprehensive client information sheet. With this sheet, we will ask you to provide some relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual fitness program for you. **Please answer all questions** in the most accurate manner possible while being as concise as possible.

Disclaimer
Please recognize the fact that it is **your responsibility** to work directly with your physician before, during, and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

Basic Information

1. What is your gender?	2. What is your age?	3. What is your date of birth?
4. What is your height?		5. What is your weight?

6. What are your specific goals?

7. Is there a specific timeline for achieving a specific goal?

8. Circle which of the two are of greater importance:

a. Immediate progress that's less easily maintained b. Maintainable progress that may not be as rapid

9. Are you currently exercising regularly? (at least 3x per week?)

10. How long have you been consistently doing so without a break?

12. On the following chart, fill in the approximate workout duration for each day, in minutes:

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Duration							

Lifestyle Information

14. What do you do for a living?	17. What is the activity level at work? None, Moderate, High
15. Does your job entail shift work? Y N	19. If you follow a more regular schedule, when do you work? Days Afternoons Nights

16. How often to do you travel? Rarely Few times per year Few times per month Weekly

18. If you have any injuries, please list them:

19. What additional therapies or interventions are being undertaken for the given injury(s)?

22. How often do you grocery shop (number per week)?

23. How many meals do you eat in restaurants or fast food places per week?

25. If you have any food allergies or sensitivities, please list them:

Screening/Exercise History Questionnaire : Please check the box for the appropriate answer		
Has your doctor ever said you have heart trouble?	☐ Yes	☐ No
Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs?	☐ Yes	☐ No
Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air?	☐ Yes	☐ No
Have you ever experienced rapid heart action or palpitations	☐ Yes	☐ No
Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	☐ Yes	☐ No
Have you ever had rheumatic fever?	☐ Yes	☐ No
Do you have diabetes, hypertension, or high blood pressure?	☐ Yes	☐ No
Does anyone in your family have diabetes, hypertension, or high blood pressure?	☐ Yes	☐ No
Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	☐ Yes	☐ No
Have you ever taken digitalis, quinine, or any other drug for your heart?	☐ Yes	☐ No
Have you ever taken medications or been on a special diet to lower your cholesterol?	☐ Yes	☐ No
Have you ever taken nitroglycerine or any other tablets for chest pain - tablets you take by placing under the tongue?	☐ Yes	☐ No
Are you under a lot of stress?	☐ Yes	☐ No
Do you drink excessively?	☐ Yes	☐ No
Do you smoke cigarettes?	☐ Yes	☐ No
Do you have a physical condition, impairment or disability, including joint or muscle problem, that should be considered before you undertake an exercise program?	☐ Yes	☐ No
Are you involved in an aerobic program? If yes, what type(s)?_____	☐ Yes	☐ No

Health and History Questionnaire

Address:	
City, Zip, State:	
Home Phone:	Work Phone:
Employer:	Occupation:
In case of emergency, please notify:	
Name:	Relationship:
Address:	
City, Zip, State:	
Home Phone:	Work Phone:

Medical Information		
Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other heal care professional for any reason? If yes, list reason:	☐ Yes	☐ No
Are you taking any medications? *(If yes, complete the following)* Type: Dosage/Frequency: Reason for Taking: _____ _____ _____	☐ Yes	☐ No
Has your doctor ever said your blood pressure was too high?	☐ Yes	☐ No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	☐ Yes	☐ No

Medical History

Please indicate in the space provided if you have any history of the following:		
Heart attack	☐ Yes	☐ No
Bypass or cardiac surgery	☐ Yes	☐ No
Chest discomfort	☐ Yes	☐ No
High Blood pressure	☐ Yes	☐ No
Rapid or runaway heartbeat	☐ Yes	☐ No
Skipped heartbeat	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No
Phlebitis or embolism	☐ Yes	☐ No
Shortness of Breath with or without exercise	☐ Yes	☐ No
Fainting or light-headedness	☐ Yes	☐ No
Pulmonary disease or disorder	☐ Yes	☐ No
High blood fat (lipid) level	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Recent hospitalization for any cause	☐ Yes	☐ No
List specifics:		
Orthopedic problems (including arthritis)	☐ Yes	☐ No
List specifics:		

For any of the conditions checked above, please list the diagnosis and examining physician:

Musculoskeletal Information

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

- ☐ Head/Neck:_____
- ☐ Upper Back:_____
- ☐ Shoulder/Clavicle:_____
- ☐ Arm/Elbow:_____
- ☐ Wrist/Hand:_____
- ☐ Lower back:_____
- ☐ Hip/Pelvis:_____
- ☐ Thigh/Knee:_____
- ☐ Arthritis:_____
- ☐ Hernia:_____
- ☐ Surgeries:_____
- ☐ Other:_____

Nutritional Information

Are you on any specific food/diet plan at this time? If yes, please list:	☐ Yes	☐ No
Do you take dietary supplements? If yes, please list:	☐ Yes	☐ No
Do you experience any frequent weight fluctuations?	☐ Yes	☐ No
Have you experienced a recent weight gain or loss? If yes, list change: Over how long?	☐ Yes	☐ No
How many beverages do you consume per day that contain caffeine?		
How would you describe your current nutritional habits?		
Other food/nutritional issues you want to include? *(food allergies, mealtimes, etc.)*		

Physical Activity Readiness Questionnaire (for Ages 15 - 69)

Being active is safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you plan on becoming more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO

☐ Yes	☐ No	
☐ Yes	☐ No	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
☐ Yes	☐ No	2. Do you feel pain in your chest when you do physical activity?
☐ Yes	☐ No	3. Int he past month, have you had chest pain when you were not doing physical activity?
☐ Yes	☐ No	4. Do you lose your balance because of dizziness, or do you ever lose consciousness?
☐ Yes	☐ No	6. Is your doctor currently prescribing drugs for your blood pressure or heart condition?
☐ Yes	☐ No	Do you know of any other reason why you should not do physical activity?

If you answered YES to one or more of these questions:

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active. Tell your doctor about the PAR-Q and which questions you answer YES.

If you answered NO to all questions: You can start becoming much more physically active — begin slowly and build up gradually. This is the safest and easiest way to go.

DELAY becoming much more active: if you are not feeling well because of a temporary illness such as a cold or fever — wait until you feel better; or if you are or may be pregnant — talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."
Name:_____

Signature:_____
Date:_____

NOTE: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions

Medical Release

It is my understanding that _____ will be participating in a fitness evaluation and exercise program. This patient is permitted to participate in the following activities.

(please check all that may apply)

1. Comprehensive physical fitness assessment including:
- ☐ submaximal aerobic capacity test for cardiovascular endurance
- ☐ resting heart rate, resting blood pressure
- ☐ body composition analysis
- ☐ flexibility
- ☐ baseline upper and lower body strength measures
- ☐ baseline upper and lower body endurance measures
- ☐ other:_____

2. Exercise/rehabilitation program including:
- ☐ Resistance exercise program
- ☐ cardiovascular exercise program
- ☐ nutritional recommendations
- ☐ other:_____

Please check the appropriate response:

- ☐ This patient may participate with no restrictions.
- ☐ This patient may participate with the following limitations:

- ☐ This patient may not participate: *(if checked, the individual with not be accepted.)*
- ☐ Other:

Diagnosis/Recommendations/Comments:

Signature

_____

PHYSICIAN NAME (Please print)

_____

PHYSICIAN SIGNATURE DATE

_____

PARTICIPANT NAME (Please print)

_____

PARTICIPANT SIGNATURE DATE

Confidentiality Agreement

I, (print name) _____, understand that the information collected by *CFIT-FITNESS LLC.* will be used for fitness evaluation purposes and for the design, implementation, progression, maintenance of an individualized fitness program only. I further understand that all such information is confidential and will not be shared with anyone without my prior written authorization, exempt in the case of a medical emergency or to the minimum extent necessary to achieve a safe and effective fitness program.

Informed Consent

I, (print name)_____, give my consent to participate in the physical fitness evaluation and body composition evaluation conducted by ___CFIT-FITNESS LLC.____.

BENEFITS

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power, and endurance.

RISKS

I recognize that exercise carries some risk to the musculoskeletal system (sprain, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

TESTING AND EVALUATION RESULTS

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, taking a step test, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide __CFIT-FITNESS LLC.___ with the essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician.

By signing this consent for I understand that I am personally responsible for my actions during my tenure at_____CFIT-FITNESS LLC._____, and that I waive responsibility of this center if I should incur any injury as a result of my negligence.

Name:_____ Signature:_____

Date:_____