



Fitness Assessment Form

Name: _____ Age: _____ Male Female (circle one)

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Daytime Phone: _____ Evening Phone: _____

Physician's Name: _____ Phone: _____

Emergency Contact Name: _____ Phone _____

YOUR HEALTH STATUS

How long has it been, since you were participated in vigorous exercise? _____

Has a physician ever told you that, you may have a heart problem? _____

Has a physician ever told you that, your blood pressure was too high? _____

Has a physician ever told you, that you have a joint problem, such as arthritis, which may be made worse by exercise? _____

Have you consulted a physician regarding, increasing your physical activity? _____

Please indicate any health conditions that apply and provide a brief explanation:

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Arthritis/bursitis _____ |
| <input type="checkbox"/> Heart condition _____ | <input type="checkbox"/> Hernia _____ |
| <input type="checkbox"/> Angina _____ | <input type="checkbox"/> Foot or knee problems _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Neck or back problems: <input type="checkbox"/> cervical <input type="checkbox"/> thoracic <input type="checkbox"/> lumbar |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Sacroiliac problems _____ |
| <input type="checkbox"/> Immune disease _____ | <input type="checkbox"/> Recent surgery _____ |
| <input type="checkbox"/> Rheumatism _____ | <input type="checkbox"/> Depression _____ |

I attest that the above information in complete and true:

Signature: _____ Date _____