

Today's Date: _____

Health and Lifestyle Profile

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Home Phone: () _____
Work Phone: () _____
Cell Phone: () _____
E-Mail Address: _____

Age: _____ Birthdate: _____
Occupation: _____

Height: _____ Weight: _____ Sex: _____
Last Physical Exam: _____

In Case of Emergency Contact: _____ Phone: _____

Referred by: Yellow pages Article/Ad in local publication
 Trainer/Client _____ (please fill-in name)
 Doctor/Health professional _____ (please fill-in name)

*Your fitness trainer wants to provide the highest quality service possible.
The following will be used to design your personal fitness program.*

1. MEDICAL HISTORY

These conditions affect your ability to exercise, please check the items which apply to you.

High Blood Pressure -Specify _____

Heart Ailment -Specify _____

Family History of Heart Disease -Specify _____

Stroke or Family History of Stroke -Specify _____

Heart Palpitations

Chest Pains

Dizzy spells or Fainting

Difficulty Breathing or _____ Asthma

Hay Fever or _____ Allergies -Specify _____

Shortness of Breath from Mild Exertion

Epilepsy

Diabetes -Specify Type I or Type II _____

Hypoglycemia

Thyroid Problems

Polio

Cancer

High Cholesterol -Specify: Triglycerides level _____ Glucose level _____

Currently under a Doctor's Care -Specify _____

Hospitalized for Illness, Injury or Surgery - Specify _____

_____ Currently on medication – List any you are taking now _____

_____ Other _____

Do you have or have you had back problems? _____ If yes, please explain problem: _____

Do you have or have you had problems in any muscles, joints, ligaments or tendons, (arthritis, calcium deposits, torn muscles, torn cartilage, tendonitis, nerve injury, bone fractures, bone dislocations, hernias, tennis elbow, etc.)?

If yes, please explain the problem and when it last occurred.

Please explain any other medical problems or accidents you have had (i.e. car, sports, a fall, etc.)

2. Lifestyle:

Do you smoke? _____ If yes, How many cigarettes a day? _____

How old were you when you started? _____

If you have quit smoking, when did you quit? _____

Do you often feel anxious, tense, or under pressure or stress? (circle one)

almost never occasionally frequently nearly constantly

How would you describe your eating habits? _____

Do you often eat FEWER than 3 meals a day? If so, which meal do you skip? (Circle one)

Breakfast Lunch Dinner

How many alcoholic beverages do you usually drink per week (circle one)

0 1-2 3-4 > 4

3. ACTIVITY PROFILE

1) How many hours of exercise do you regularly do each week? _____

2) Please List:

ACTIVITY	FREQUENCY	SINCE WHEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever participated in any of the above activities on a competitive or professional level?

3) Are you aware of your working heart rate and if so what range do you work in? _____

4) **GOALS:** Please list 5 goals

1. _____
2. _____
3. _____
4. _____

5. _____

To the best of my knowledge, all of the above statements are complete and true.

Signature: _____ Date: _____

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