

Core Intervention

no rules.....only choices

FITNESS ASSESSMENT /HEALTH STATUS

Name _____ Date _____

Occupation _____ Male _____ Female _____

Address _____ State _____ Zip _____

e-mail _____ Phone _____

Emergency contact _____ Phone _____

Birth Date _____ Age _____ Height _____ Weight _____

Present/Past History

I.RISK FACTORS

- ___ 1. Have any of your parents or siblings had a heart attack, bypass surgery, angioplasty or sudden death prior to the age of 55(male relative) or 65(female relative)?
- ___ 2. Have you smoked cigarettes in the past 6 months?
- ___ 3. Do you take blood pressure medication?
- ___ 4. Is your usual blood pressure 140/90 or more?
- ___ 5. Is your Fasting Glucose level >100?(if you know it)
- ___ 6. BMI (>30?) _____ waist girth(>100cm?) (We will measure these during assessment)
- ___ 7. Do you get at least 30min of moderate physical activity most days of the week?

II.SYMPTOMS

- ___ 1. Do you ever have pain or discomfort in your chest or surrounding areas (ie, ischemia)?
- ___ 2. Do you ever feel faint or dizzy (other than when sitting up rapidly)?
- ___ 3. Do you find it difficult to breathe when you are lying down or sleeping?
- ___ 4. Do your ankles ever become swollen (other than after a long period of standing)?
- ___ 5. Do you ever have heart palpitations or unusual period of rapid heart rate?
- ___ 6. Do you ever experience pain in your legs (ie. intermittent claudication)?
- ___ 7. Has a physician ever said you have a heart murmur? (Has he said it is OK and safe to exercise?)
- ___ 8. Do you feel unusually fatigued or find it difficult to breath with usual activities?

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III.OTHER

- ___ 1.How old are you?(Men>45, women>55 are at moderate risk)
- ___ 2.Do you have any of the following diseases? Circle if “yes”
**Heart disease Peripheral vascular disease Thyroid disorder Asthma Diabetes
COPD(emphysema, chronic bronchitis) Liver disease Renal disease Cystic fibrosis**
- ___ 3. Do you have any bone or joint problems, such as arthritis or a past injury, that might get worse with exercise?
- ___ 4. Do you have a cold, flu or any other infection?
- ___ 5. Females: Are you pregnant?
- ___ 6. Do you have any other problems that might make it difficult for you to do strenuous exercise?

ACTIVITY HISTORY/GOALS

- 1.Are you currently exercising?___how long?___months. How many days a week?_____.
What
equipment?_____
- 2.Have you ever performed resistance training in the past? Yes___No___
- 3.List your personal, health and fitness goals. Examples: lose weight, general fitness, muscular strength, improve diet,stop smoking, sports specific, muscular size, improve health, look and feel better._____

- 4.What areas of your body do you want to improve the most?_____
- 5.Have you ever worked with a personal trainer before?Yes___No___
- 6.How many days a week are you planning to work out? On a scale of 1-10 (1 being the lowest & 10 being highest), what is your level of commitment?_____
- 7.Do you or have you followed any specific dietary plan? (ie. Weight watchers, Atkins, Sugar Busters.....)How do you feel about your nutritional habits?_____
- 8.List any Medications you are currently taking_____
- _____
- _____

I certify that the above statements are true. I understand that a Doctor’s note may be requested and this workout should not proceed until it is obtained.

Participants

Signature_____ **Date**_____