YOUR LETTERHEAD HERE

Client Initial Assessment Form Date:_____

Name:_____ Phone H,C,W _____ T/C
Address:_____
Occupation:_____D.OB._____
Email:_____ Emergency Contact:_____
Have you ever had personal training before? Y__ N__ Last Session:_____ Focus: _____
Name of GP _____ phone: _____ Did your health care practitioner refer you to engage in physical activity? Y__N__ Details_____

MEDICAL HISTORY

Please indicate conditions you are **C**urrently experiencing or have experienced in the **P**ast

High blood pressure	c	p	Shortness of breath	c	p	Vision problems	c	P
Low blood pressure	c	p	Bronchitis	c	p	Auditory problems	c	P
Chronic congestive heart failure	c	p	Asthma	c	p	Inner Ear problems/Balance	c	P
Heart attack	c	p	Emphysema	c	p	Pregnant Due_____	c	P
Varicose veins	c	p	HIV	c	p	Post-partum DOB_____	c	P
Stroke	c	p	Arthritis	c	p	Bone/Joint disease	c	P
Pacemaker	c	p	Allergies _____	c	p	Joint pain	c	P
Heart disease	c	p	Epilepsy	c	p	Muscle pain	c	P
Heart blockage	c	p	Osteoporosis _____	c	p	Muscle damage	c	P
Diabetes onset_____	c	p	Fainting/Dizzyness	c	p	Surgery _____	c	P
Cancer onset _____	c	p	Smoker	c	p		c	P

Are you taking ANY medications? Y__ N__ For what condition? _____ Details _____
_____
Do you have any internal pins, wires, artificial joints or special equipment? Y__ N__
Details _____
Are you currently receiving treatment from a health care provider? Y__N__ Details:_____
_____
Previous injuries:_____
_____
Current injuries:_____
Functional Limitation:_____
_____
_____

Objective Information:

Posture:_____
_____
Gate: _____
_____

Girth: Chest – pit/nip_____ Waist – narrow/button _____ Hip_____ Thigh_____
Height_____ Weight_____ Clothing:_____
Resting HR_____ Resting BP_____ Resting BGlocose_____

YOUR LETTER HERE

EXERCISE INFORMATION

What do you hope to accomplish through your personal training sessions?

Weight loss		Rehab joint/muscle injury		Knowledge	
Weight gain		Rehab cardiovascular illness		Independence	
Muscle toning		Rehab cancer		Experience	
Muscle building		Prepare for Pregnancy		Self confidence	
Flexibility		Rehab Post-partum		Sport Specific Training	
New program		Smoking cessation		Compliment other training	

Specific Goals:

S_____ M _____ A _____ R_____ T _____

S_____ M _____ A _____ R_____ T _____

S_____ M _____ A _____ R_____ T _____

S_____ M _____ A _____ R_____ T _____

Have you ever followed a physical fitness program? Y__ N__ Past or Present? _____

What kind of activities do you do?_____

Likes:_____

Dislikes:_____

Current Routine:_____

Barriers to achieving goals: _____

Availability: _____

Physical Fitness Assessment

RHR_____						
Cardiovascular						
5 min warm equip_____	sp_____	lev_____	Dist_____	H.R./R.P.E._____		
Test 5min___ 10 min___ 1 km___	sp_____	lev_____	Dist_____	H.R./R.P.E._____		
5 min cool down	sp_____	lev_____	Dist _____	H.R./R.P.E._____		
Muscular Strength – 8-12 rep max = 70-80% max						
Squat__ Leg Press__ Wall Squat__	Reps_____	Wght_____	Rest_____	R.P.E._____	_____%	
Chest Press bench__ floor__ incline__	Reps_____	Wght_____	Rest_____	R.P.E._____	_____%	
Lat pull__ Low Row__	Reps_____	Wght_____	Rest_____	R.P.E._____	_____%	
Muscular Endurance						
____push ups __ wall sit__ crunches__	Reps_____	Time_____	Rest_____	R.P.E._____	_____%	
Flexibility						
Sit and reach_____ opp arm connect behind back R. over_____ L. over_____						
RHR_____						

Additional Notes: