Fitness Assessment Form

CLIENT INFORMATION

Name: _____ Preferred name: _____

Patient ID: _____ Sex: _____

Preferred pronouns: _____ Date of birth: _____ dd / mm / yyyy

Marital status: _____ Address: _____

Email: _____ Contact information: _____

EMERGENCY CONTACT

Contact #1 Full name: _____ Relationship: _____

Contact number: _____ Contact #2 Full name: _____

Relationship: _____ Contact number: _____

MEDICAL HISTORY

Current/past medical conditions:

Current/past physical injuries:

Past surgeries:

Current/past medications:

Do you smoke, drink alcohol, or take recreational drugs?

◯ Yes ◯ No

If so, please elaborate:

How many hours of sleep do you get each night, on average?:

Describe your typical daily meals:

What is your current level of stress from 1 (worst) and 10 (best)?:

What are your sources of stress?

PHYSICAL HEALTH INFORMATION

Height: _____ Weight: _____

BMI: _____ Body fat %: _____

Do you engage in physical activity?

- ◯ Yes, currently with a physical trainer.
- ◯ Yes, with a physical trainer in the past, but currently independently.
- ◯ Yes, independently.
- ◯ No
- ◯ Other

If so, please elaborate (how often, what type, intensity level, etc.):

What are your physical health goals?

- ☐ Weight loss
- ☐ Muscle gain
- ☐ Be physically fit
- ☐ Improvement in sports performance
- ☐ Improve overall health
- ☐ Other

FITNESS EVALUATION

Muscular strength:

Muscular endurance:

Cardiovascular endurance:

Flexibility:

Other:

TRAINING PREFERENCES

Please elaborate on your training preferences (training frequency, workout time, favorite exercises, motivation, etc.):

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccuracy information can be dangerous to my health.

Client's signature:

Date: _____ dd / mm / yyyy