Personal Trainer Assessment

PATIENT INFORMATION

Full Name: _____ Age: _____

Gender:

◯ Male ◯ Female ◯ Other

Height: _____ Weight: _____

Body Mass Index (BMI): _____ Occupation: _____

Contact Information: _____

HEALTH HISTORY

Medical Conditions:

Previous Injuries:

Allergies:

Medications:

Family History:

CURRENT FITNESS

Exercise Habits:

Fitness Goals:

Dietary Habits:

Sleep Patterns:

Stress Levels:

INITIAL CONSULTATION

Initial Consultation:

MOVEMENT ASSESSMENT

Posture Analysis: _____ Mobility: _____

Stability: _____

BODY COMPOSITION TEST

Body Fat Percentage: _____ Muscle Mass: _____

Weight-to-Hip Ratio: _____

WORK CAPACITY TEST

Cardiovascular Fitness Strength:

LOADED ASSESSMENTS

Weightlifting Technique:

Resistance Training:

ADDITIONAL INFORMATION

Smoking Status: _____ Alcohol Consumption: _____

Recreational Drug Use: _____

Additional Comments: