Personal Training Assessment Form

PATIENT INFORMATION:

[ClientInfo]: _____ Email: _____

MEDICAL HISTORY

Diseases (if any):

Chronic conditions (if any):

Past surgeries (if any):

Allergies (if any):

FITNESS OR EXERCISE HISTORY

Have you ever participated in any sports, physical training, fitness activities, or training programs before?

◯ Yes ◯ No

If yes, please describe:

Do you have any preferred exercises or activities?

◯ Yes ◯ No

If yes, please describe:

Have you suffered any past injuries or chronic pain due to your activities?

◯ Yes ◯ No

If yes, please describe:

LIFESTYLE OR HEALTH HABITS

Do you smoke?

◯ Yes ◯ No

How often: _____

Do you consume alcohol?

◯ Yes ◯ No

How often: _____ **Average hours of sleep per night:** _____

Rate your daily stress levels from 1-10, with 10 being highly stressed:

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

How often do you exercise: _____

What type of exercises do you usually do:

Please describe your typical daily diet:

FITNESS GOALS

Body measurements (to be filled out by the trainer):

Weight: _____ **Height:** _____

Body fat %: _____ **Other:** _____

Other test results (to be filled out by trainer):

Check all that apply and provide a description for each test result.

Check all that apply:

- ☐ Cardiovascular fitness
- ☐ Muscular strength
- ☐ Endurance
- ☐ Flexibility
- ☐ Other

Notes:

WAIVERS OR CONSENT

I, understand that participating in a fitness program has certain risks, and I hereby release to the trainer/company from any liability for injuries or damages incurred during the training program.

Signature:
Date: _____ dd / mm / yyyy

I consent to the use of my information solely to develop a personalized fitness plan, and I understand that this information will be kept confidential.

Signature:
Date: _____ dd / mm / yyyy

TRAINER'S NOTES

Initial assessment notes:

Training plan recommendations:

Name: _____

Signature:
Date: _____ dd / mm / yyyy