

# Future Fitness Student Personal Analysis

## Health History

1. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_
4. Past and Present Health History (check if applicable)

- Diseases of the heart and arteries
- Abnormal electrocardiogram (ECG)
- High blood pressure
- Angina pectoris (chest pain)
- Epilepsy
- Stroke
- Anemia
- Abnormal chest X-ray
- Cancer
- Asthma
- Other lung disease
- Orthopedic or muscular problems
- Diabetes

If any of the above are checked, please explain further and indicate any recommendations your doctor has made regarding exercise.

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### 5. Level of Physical Activity

Are you currently involved in a regular aerobic exercise program such as walking, jogging, cycling, swimming, step aerobics etc.?

- No
- Yes

Are you currently participating in weight training?

- No
- Yes

Do you perform stretching exercises on a regular basis?

- No
- Yes

What best describes your level of physical activity during the past 4-6 weeks.

- Very Active
- Moderately Active
- Inactive

6. Please list below any additional exercise information that you think is important for us to know prior to participation.

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7. Is there a family history of heart disease, hypertension, stroke, diabetes, heart failure, lung disease, or epilepsy?

- Yes
- No

If yes, please provide information regarding who the relative is, the medical problem, and the age at onset or death:

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8. Do you smoke?

- No
- Yes How much per day? \_\_\_\_\_

9. Are currently taking medication prescribed by a physician?

- No
- Yes Indicate name of medication and reason why you are taking it:

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10. Please indicate below any additional medical information that you think would be important for us to know prior to participation.

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### Goals

Please CHECK all of the benefits in which you are most interested, THEN label each column in order of importance, from 1-4.

HEALTH	APPEARANCE	PERFORMANCE	SELF-DEFENSE
<input type="checkbox"/> Physical Fitness	<input type="checkbox"/> Weight Control	<input type="checkbox"/> Stamina	<input type="checkbox"/> Safety
<input type="checkbox"/> Stress Reduction	<input type="checkbox"/> Muscle tone	<input type="checkbox"/> Flexibility	<input type="checkbox"/> Confidence
<input type="checkbox"/> Relaxation	<input type="checkbox"/> Posture	<input type="checkbox"/> Mental Focus	<input type="checkbox"/> Awareness

Order of Importance:

\_\_\_\_\_

What specifically would you like to accomplish in our fitness program?

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### Informed Consent

The undersigned hereby gives informed consent to engage in a series of procedures relative to completing a written medical/health history, taking a battery of exercise tests, and participating in a variety of physical activities. The purpose of the testing is to train workshop participants on techniques to determine physical fitness, cardiovascular function, and health status. All exercise testing and physical activity sessions will be supervised and monitored by trained exercise technicians. These activities include walking, running, weight training, and callisthenic exercises performed in either field or gymnasium setting.

There exists the possibility that certain detrimental physiological changes may occur during exercise and exercise testing. These changes could include heart related illness, abnormal heartbeats, abnormal blood pressure, and in rare instances, a heart attack. If abnormal changes were to occur, the staff has been trained to recognize symptoms and take appropriate action, including and administering CPR and first aid.

I have read this form and understand that there are inherent risks associated with any physical activity and recognize it is my responsibility to monitor my individual physical performance during any activity.

In the event of a medical problem, I further recognize that any medical care that may be required is my personal financial responsibility. Finally, I give informed consent for testing data to be used in an anonymous manner for purposes of scientific and medical research.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### THIS SECTION FOR STAFF USE ONLY

Employer & Position \_\_\_\_\_

Spouse \_\_\_\_\_ Will spouse be participating? \_\_\_\_\_

##### ACSM Classification

- Apparently Healthy
- Individual at Higher Risk
- Individual with Disease

##### Category of Risk

- Orthopedic
- Cardiovascular
- Chronological
- Psychological

List any comments that you (the trainer) believe to be important in determining the risk status of this client. This would include special considerations of alternative assessments, etc.

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Trainer Signature: \_\_\_\_\_ Date: \_\_\_\_\_