

**Client Health and Physical Activity Worksheet**

Name: \_\_\_\_\_ Trainer: \_\_\_\_\_  
 Address: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_  
 \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone: Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Emergency Contact-Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Salesperson: \_\_\_\_\_ # of Sessions purchased: \_\_\_\_\_  
 Type of payment: Visa/MC    Check    Cash  
 Amount of sale: \$ \_\_\_\_\_ Payment received (circle): YES    NO

**1. Which days and times are best for you?**

	Time
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____

Start date: \_\_\_\_\_  
 How often: \_\_\_\_\_  
 Forms completed:  
 Health History            Yes            No  
 Participant Release      Yes            No  
 Billing Agreement        Yes            No  
 Doctor's Release         Yes            No

**2. Please check if applicable**

	Client		Family		If Yes, Describe
	YES	NO	YES	NO	
Diabetes	___	___	___	___	_____
High Blood Pressure	___	___	___	___	_____
High Cholesterol	___	___	___	___	_____
Smoke or use tobacco products	___	___	___	___	_____
Angina/Chest Pain	___	___	___	___	_____
Heart Murmur	___	___	___	___	_____
Irregular Heart Beats	___	___	___	___	_____
Abnormal Electrocardiogram	___	___	___	___	_____
Rheumatic Fever	___	___	___	___	_____
Thrombophlebitis	___	___	___	___	_____
Respiratory Infections	___	___	___	___	_____
Asthma	___	___	___	___	_____
Embolism	___	___	___	___	_____
Aneurysm	___	___	___	___	_____
Stroke	___	___	___	___	_____
Valve Disease	___	___	___	___	_____
Heart Attack	___	___	___	___	_____

**3. Do you have any of the following conditions that may limit your physical activity? (check all that apply)**

Ankle/Foot Injury     Bone Fracture     Shoulder/Clavicle Injury     Arthritis  
 Low Back Pain     Wrist/Hand Injury     Arm/Elbow Injury     Knee/Thigh Injury  
 Hip/Pelvic Injury     Calcium Deposits     Nerve Damage     Tennis Elbow  
 Upper Back Injury     Head/Neck Injury     Other

If other, please explain: \_\_\_\_\_

4. Has your physician ever advised you against exercise?     Yes     No  
 5. Are you presently receiving physical therapy?     Yes     No

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6. Are you presently taking any medications?  Yes  No If yes, please list names and dosages of each: \_\_\_\_\_  
\_\_\_\_\_
7. Are you involved in an exercise program at the present time?  Yes  No  
If yes, please describe the program: \_\_\_\_\_
8. How would you rate the amount of physical activity at work?  
 Very Little  Little  Moderate  Active  Very Active
9. How would you rate the stress level of your job?  
 Little  Moderate  Stressful
10. When exercising, including climbing stairs, do you ever experience any of the following? (check all that apply)  
 Chest Pains  Shortness of Breath  Pressure over the Heart  A Tired-Out Feeling  
 Leg Aches  Dizziness
11. Have you ever had a stress test?  Yes  No  
If so, date of most recent test: \_\_\_\_\_  
Results:  Normal  Abnormal
12. What was your weight one year ago?  Five years ago?  At age: \_\_\_\_\_
13. Do you follow any special diet at the present time?  Yes  No  
If so, what type?  
 Low Cholesterol/Low Fat  Low Salt  Reduced Calorie  Liquid Diet  Other  
If other, please specify: \_\_\_\_\_
14. What are your personal exercise program goals?  
 Weight Control/Loss  Staying in Shape  Stress Reduction  Increasing Strength  
 Cardiovascular Conditioning  Other  
If other, please specify: \_\_\_\_\_
15. What equipment do you presently have?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. Any additional information or comments before beginning your exercise program?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_