

General Fitness Evaluation and Program Participation

Date: _____

NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ AGE: _____ SEX: _____

EMAIL: _____

WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

What is the present state of your general health?

Physician's Name: _____ Phone: _____

Person to contact in case of emergency? _____

Phone: _____

Are you presently taking medication? _____

Are you now or have you been pregnant within the past three months? _____

Does your physician know you are participating in an exercise program? _____

Do you have now or have you had within the past year:

	YES	NO
1. A history of heart problems	_____	_____
2. High blood pressure	_____	_____
3. Difficulty with physical exercise	_____	_____
4. A chronic illness	_____	_____
5. Advice from a physician not to exercise	_____	_____
6. Muscle, joint, or back disorder that could be Aggravated by physical activity	_____	_____
7. Recent surgery (w/in past 3 months)	_____	_____
8. History of lung problems	_____	_____
9. Diabetes	_____	_____
10. Cigarette-smoking habit	_____	_____
11. High blood pressure	_____	_____
12. History of heart problems in immediate family	_____	_____

What regular physical activity do you presently do?

Signature: _____