

Denver Fitness Trainer—Lee Cherry— Online Exercise Program
Health and Fitness History

Name: _____ Date: _____

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Medical

Has a doctor or health professional ever told you that you have or have had any of the following conditions? *Fill in circle.*

- Family History of Heart Disease
- Asthma
- High Cholesterol
- Stroke
- Diabetes
- High or Low Blood Sugar
- Emphysema
- Epilepsy
- Cancer

Do you have any of the following?

- Back Pain
- Joint Replacement/Repair
- Joint, Tendon or Muscular Pain
- Osteoporosis
- Pacemaker

Are you currently taking any medication that would affect the following?

- Heart Rate Y N
- Blood Sugar Y N
- Balance Y N

Please list any other condition, injury or recent surgeries that you feel I should know about in planning a fitness program for you:

Lifestyle

What is your current occupation?

Does your occupation require extended periods of sitting?

Does your occupation require extended periods of repetitive movements? (if yes, please explain)

Does your occupation require you to wear shoes with a heel (dress shoes)?

Does your occupation cause you anxiety? (mental stress)

Which best describes your current smoking status?

- I have NEVER smoked, or quit more than 6 months ago.
- I CURRENTLY smoke, or quit within the last 6 months.

Do you consider your daily job or daily activities to be: Sedentary or Active

Please describe your current exercise choices. *Fill in one.*

- Generally sedentary
- A vacation/weekend exerciser
- Physically active monthly (If this, how many times a month? _____)
- Physically active weekly (If this, how many times a week? _____)

Are your current exercise choices (length, intensity, etc) different from your past exercise choices? Y N

If yes, describe:

Do you partake in any recreational activities/sports?

Were you ever a semi or professional athlete? If so, please explain in detail.

Training Goals

How much time do you want to spend working out?

What do you hope to accomplish, ie results (injury prevention, toned, more flexible, increased muscle mass, weight loss?)

Current Primary Care Physician:

Name:

Address:

May we send a letter to your primary care physician to let them know we are working together?

If so, Please sign below.

I give my permission to Lee Cherry to contact my current physician.

Sign _____