

Fitness Assessment Form

Client Information				
First Name	Last Name	Preferred Name	Patient ID	
Gender	Preferred Pronouns	Date of Birth	Marital Status	
Address		City	State	Zip Code
Email		Preferred Phone Number		
Emergency Contact				
Full Name		Relationship	Contact Number	
Full Name		Relationship	Contact Number	
Physical Health Information				
Body Composition				
Height	Weight	BMI	Body Fat %	
Current/past health conditions				
Current/past physical injuries				
Current medication				
Are you a smoker? If so, please elaborate				
How many times do you exercise a day, and what kind of exercise do you do?				

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Physical Health Information (Continued)

Describe your typical daily meals (breakfast, lunch, dinner)

What are your physical health goals

Weight Loss Gain Muscles Be Physically Fit Sport Performance Improve Overall Health

Other:

Fitness Evaluation

Muscular Strength

Muscular Endurance

Cardiovascular Endurance

Flexibility

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my health.

Signature of Client 	Date
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