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?

Client Information

First Name	Last Name	Date of Birth	Patient ID

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