# Client Initial Assessment Worksheet

Name: _____ Date: _____
Address: _____ City_____ ST____ ZIP_____
Contact Numbers: (HM) _____ and (Cell) _____
Email: _____

Gender: □ Male □ Female Date of Birth: _____ Height: _____

Emergency Contact:
Name: _____ Number: _____

(If female – Are you lactating or pregnant? □Yes or □ No)

**How did you here about us or who referred you? _____**

**Which of the following statements best describe you (check one):**
□ I can eat practically anything I want and I do not gain weight. I find it very hard to gain weight.
□ I can lose or gain weight by adjusting my activity level and eating habits.
□ I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

**Please rate the activity level of your profession or what you during the day (excluding exercise):**
□ Sedentary □ Moderately Active □ Active □ Very Active

**What are your weight goals (circle one):**
□ Weight Loss **What is your goal weight? _____**
□ Maintaining/Improve Eating Habits
□ Weight Gain

**To Be Completed By Your Personal Trainer**

**Physical Assessment Data:**

**A. Body Weight (lbs.):** _____

**B. Body Fat %:**
□ BIA (Body Fat %) _____

**Metabolic Assessment Data:**

**A. Resting Metabolic Rate (calories)** _____

**Fitness Assessment Data:**

**A. Cardio Endurance:** 3 Min. Step Test (bpm) _____

**B. Upper Body Strength:** Push Ups (#) _____

**C. Abdominal Strength:** 1 Min. Sit ups (#) _____

**D. Lower Body Strength:** Squat Test (#) _____

**E. Flexibility** Sit & Reach (inches) _____

## MEDICAL HISTORY

1. When was your last physical examination? _____

2. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? **Y / N**
_____

3. Do you have a seizure disorder (epilepsy)? **Y / N**
_____

4. Do you take any prescribed medication on a permanent or semi-permanent basis? **Y / N** If Yes, List Any Medications:
_____
_____

5. Do you have diabetes Adult or Juvenile? **Y / N**

6. Have you ever been found to be anemic (low blood count)? **Y / N**

7. Do you have High Blood Pressure (hypertension)? **Y / N**

8. Do you currently have high cholesterol? **Y or N** What is it? _____

9. Any cardiovascular problems (abnormal heartbeat, heart attacks etc.) **Y or N**
Explain: _____

10. Do you smoke? **Y / N** If Yes, how many per day? _____

11. Do you drink beer/alcohol? **Y/ N** If Yes, How many per week? _____

12. Have you been under the guidance/advice of a psychologist? Explain.
_____
_____

13. . Have you had any surgeries pertaining to gastro bypass or lap band? If so, please list dates of surgery. _____

14. Do you have any medical conditions or problems than cause pain not previously mentioned? If yes, explain.
_____
_____