Wellness Corporation Fitness and Medical Assessment

PERSONAL DETAILS First name:

Sex:

Surname:

☐ Male

Date of Birth:

☐ Female

_____/_____/

Address:

_____

_____

Telephone: Home:_____Work:_____Mobile:_____

Emergency Contact

Name: _____

Telephone: Home:_____Work:_____Mobile:_____

MEDICAL HISTORY

Doctor: _____ **Date of last check up**_____/_____/_____

Please circle YES or NO to each of the following questions.

- **Has anyone in your family under 60 suffered heart disease, stroke, raised cholesterol or sudden death?** YES NO
- **Are you pregnant?** YES NO
- **Have you given birth within the last 6 weeks?** YES NO
- **Do you have any infectious diseases?** YES NO
- **Have you been hospitalised recently?** YES NO
- **Are you taking any medication at present?** YES NO

If so, give details _____

- **Have you ever had or do you have any of the following:** (Please circle)

Diabetes	Rheumatic Fever	Raised Cholesterol
Epilepsy	Heart Murmur	Arthritis
Hernia	Dizziness or Fainting	Asthma
Liver or Kidney condition	Stomach or Duodenal Ulcer	Neck/Back pain
Glandular Fever	Any Heart Condition	Knee Pain

High Blood Pressure >140/90 | Palpitations or Chest Pains | Other Joint pain, Muscular pain or Cramps

If you circled any of the above please give details _____

_____

- **Do you smoke?** YES NO If YES how many a day? _____
- **Are you dieting or fasting?** YES NO

Please give details _____

- **Do you suffer from Stress and/or Insomnia?** YES NO
- **Have you been doing any exercise recently?** YES NO

Type of activity: _____

Intensity level: Easy Moderate Hard

- **What do you hope to achieve from circuit classes and/or personal training sessions/programs?** (Please circle)

Weight Loss | Increased Strength | Increased Fitness

Weight Gain | Increased Stamina | Rehabilitation Other

_____

Please read the following statement carefully

I understand this information is to be used as a guide to provide me with a suitable exercise program based on my current medical condition. I understand that if medical clearance is required, I will consult my physician and obtain a clearance.

I agree to advise the trainer immediately there is any change in my medical condition or if I experience any discomfort while training.

I agree and accept that the Wellness Corporation or its officers or employees will not be liable for any personal injury or damage to my property while I am participating in any activity in the Wellness Corporation or any injury or damage resulting in any undisclosed medical conditions or issues.

Signature: _____ Date: _____

Print Full name: _____

Vital Statistics and Measurements

	Start	Goal	Eval 1	Eval 2	Eval 3
Date					
Height					
Weight					
Resting heart rate					
Training heart rate					
Skin fold measurement					

bicep					
Skin fold measurement tricep					
Skin fold measurement subscapular					
Skin fold measurement supralliac					
% body fat					
% lean mass					
Neck					
Chest					
Biceps (right/left)					
Forearms					
Waist					
Hip					
Upper thigh (right/left)					
Calf					

OFFICE USE ONLY

Medical clearance required YES NO

Comments _____