CLASSIC FITNESS & WELLNESS PROFILE

Today's Date ____/_____/_______

Please print all information. Thank you

Last Name _________________________

First Name _________________________

Email: __________@ ______________

Telephone ___________________

Cell ________________________

Work _______________________

Fax ________________________

Home Address

____

____

____

Business Address

____

____

____

Birth Date ____/_____/ 19____ Age______ Height _______ Weight_______

Person to notify in an emergency Telephone #

____________________________ ____________________

Personal Physician Telephone #

____________________________ ___________________

PHYSICAL ACTIVITY:

Are you presently involved in any kind of exercise/sport/physical activity on a regular basis? If so, please describe.

____
____
____

How would you rate the amount of physical activity you perform during your
leisure time: very little _____ little ____ moderate ____ active _____
work time: very little _____ little ____ moderate ____ active _____

Do you start physical fitness programs but then find yourself unable to stick with them?
Yes ____ No ____

Can you exercise during your workday? Yes ___ No ___

In what way do you cope with stressful situations?

____
____

Which of these activities have you enjoyed in the past or would like to try in the future?

Walking _____________
Running _____________
Swimming _____________
Cycling _____________
Strength training _______
Yoga/meditation ________
Pilates ________________
Stationary cycling ___________
Rowing ___________________
Racquetball ________________
Tennis ____________________
Stretching __________________
Hiking _____________________
Elliptical training_____________

Other ____

Do you have any negative feelings toward or experiences with physical activity programs? If so, please explain.

____
____

Please evaluate your own level of physical activity during different time periods of your life on a scale of 1 (extremely low) to 5 (very strenuous) for each age range through the present.

15-20 ____ 21-30 ____ 31-40 ____ 41-50 ___ 51-60 ____ 60 ____ over 70 ___

NUTRITIONAL LIFESTYLE

What has been your lowest and highest weight during your adult life?
_________lbs. _______ lbs.

Briefly describe your dietary habits: types of foods, quantities, frequency of meals, time of meals, and anything else which pertains to your nutritional lifestyle.

____
____
____

Are you presently on any nutritional plan to lose or gain weight? Yes __ No __

If so, describe: ____

If you consider yourself underweight or overweight, to which of the following factors do you attribute it?

Large meals _____ Emotional _____ Social _____ Travel _____ Snacking _____
Business meals _____ Other, please describe _______________________________

Do you drink coffee? Yes ___ No ____ How much? ________/day
Do you drink alcohol? Yes ___ No ____ How much ? ________/day
Do you smoke cigarettes? Yes ___ No ____ Packs/day _____
If you <u>do not</u> smoke now, have you smoked in the past? Yes ____ No ____

If so, how long has it been since you stopped? _____________

Do you have any dietary restrictions or allergies?

____
____

Are there any foods you absolutely do not like and will not touch?

____

Are you taking any nutritional supplements? If so, please list.

____
____

Is there anything else that may affect your ability to to change your nutritional lifestyle at this time?

____
____

MEDICAL HISTORY

Have you been under the care of a physician for any reason during the past year? If so, for what reason?

____

(Women) Are you pregnant? Yes _____ No ________

Are you taking any prescribed medications? Please list by name, dosage and the reason.

____

____

____

Family History

Have any members of your family (parents, sisters, brothers, or grandparents) had any of these health problems?

Heart disease	Yes _______	No _______
High blood pressure	Yes _______	No _______
High cholesterol	Yes _______	No _______
High triglycerides	Yes _______	No _______
Diabetes	Yes _______	No _______
Stroke	Yes _______	No _______

Personal Health History

Please check Yes or No if you have had or have any of the following conditions.

	Yes	No
Heart Disease	___	___
Rheumatic fever	___	___
Diabetes	___	___
Anemia	___	___
Heart palpitations, skipped beats	___	___
Tachycardia	___	___
Bradycardia	___	___
Chest pain at rest	___	___
Chronic coughing	___	___
Fainting/dizziness	___	___
High blood pressure	___	___
Shortness of breath with activity	___	___
Hypoglycemia	___	___
Epilepsy or convulsions	___	___
Stroke	___	___
Surgery	___	___
Blood disorder ___		
Cancer of any kind	___	

Please explain "Yes" answers within the above list

____

____

Orthopedic History

Please describe any past or present musculoskeletal conditions you have experienced related to each of the following areas.

Head/neck ____
Shoulder ____
Upper back____
Lower back____
Upper arm____
Lower arm ____
Hands ____
Hips/pelvis ____
Knees____
Thighs____
Ankle/feet____
Other____

Do you have any arthritis, bursitis, osteoporosis or other chronic condition of this nature? Explain

____

____

____

This concludes your profile.

If there is anything that you feel has <u>not been discussed</u> that may be relevant and allow you to participate in an effective wellness coaching program – please describe below.

____

____

____

____

Please sign and date:

______________________________ ____________________________________

Participant's Signature / Date Instructor's Signature
(Parent or Guardian if under 18)