

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	