

The Tower of Fitness

PERSONAL TRAINING

PREPARTICIPATION PHYSICAL EVALUATION

Name:	Sex:	Age:	Date of Birth: / /	Date of Evaluation: __/__/__
-------	------	------	--------------------	------------------------------

Explain "Yes" answers below. Circle questions you do not know the answer to.

- | | |
|--|---|
| <p>1. Do you have an ongoing or chronic illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are you currently taking any prescriptions or nonprescription (over-the-counter) medications or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury, concussion, or seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>6. Recent surgery (less than 12 months) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Diabetes or thyroid condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FEMALES ONLY</p> <p>8. Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you recently (within one year) given birth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|--|---|

Explain "Yes" answers here:

If yes, check the appropriate box below.

- | | | |
|------------------------------------|----------------------------------|------------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Elbow | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh |
| <input type="checkbox"/> Back | <input type="checkbox"/> Wrist | <input type="checkbox"/> Knee |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Hand | <input type="checkbox"/> Shin/calf |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Finger | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Upper arm | <input type="checkbox"/> Foot | |

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of client _____

Date _____

OFFICE USE ONLY

General Physiological Information:

Height: _____ ft. _____ in. Weight: _____

Blood Pressure: _____ mm Hg RHR _____
Systolic/Diastolic

Predicted Max HR: _____ 80% _____

70% _____

60% _____

Body Composition: A. Skin Folds

Chest: _____

Suprailiac: _____

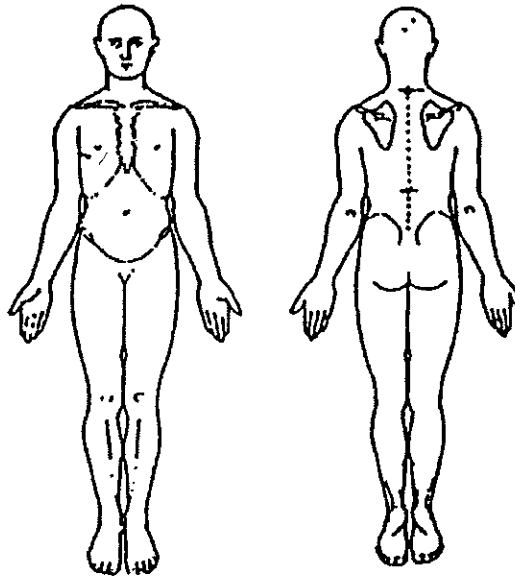
Abdominal: _____

Tricep: _____

Ant. Thigh: _____

Total Skin Folds: _____

B. Body Fat: Percent Fat _____ %



TRAINER NOTES: