



# FITNESS INTAKE

**\* Please arrive 5 min. prior to scheduled appointment time. Remember to bring Completed Paperwork.**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Sex:  M  F DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed  Separated

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you give permission to update your general medical practitioner with your progress? YES NO

Name of Medical Doctor: \_\_\_\_\_ Whom may we thank for referring you to us? \_\_\_\_\_

## HEALTH HISTORY

1. Have **you** or **anyone** in your immediate **family** suffered from (circle):

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Neck pain    |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Back pain    |
| <input type="checkbox"/> Aneurysm       | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Knee pain    |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Foot pain    |
| <input type="checkbox"/> Skin condition | <input type="checkbox"/> Depression          | <input type="checkbox"/> Other: _____ |

2. Have you ever had any **serious illnesses**? NO YES Describe: \_\_\_\_\_

3. Have you ever had **surgery or been hospitalized**? NO YES Describe: \_\_\_\_\_

4. Any **major trauma's**? (i.e. Falls, Car accidents, Work related injuries, Fractures?) NO YES

5. Are you taking any **medications**? ? NO YES List: \_\_\_\_\_

6. Are you taking any **supplements**? NO YES List: \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(If client is under 18)

## CHECKLIST FOR FALLING WATERS USE ONLY

### Packet review:

- Fitness Intake
- Fitness Consult Intake (*Health Q, Hx & Profile*)
- PAR-Q (*must pass or sign medical release prior to orientation or regular classes*)
- Waiver, Release and Assumption of Risk signed
- Fitness Policy (*to be reviewed with client & signed*)

### Scheduling:

- Contact info given to client for scheduling
- Date & Time for scheduling Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Client Scheduled

### Processing Information: (*Paper clipped & hand delivered to FD*)

- Fitness Rx: (Filled out for Front Desk)
- Intake Forms/packet for Front Desk review

\*\* Trainers to ensure ALL documents are filled out completely. (name, date, initial & signatures where indicated.)

Trainers Signature: \_\_\_\_\_

# PERSONAL HEALTH & FITNESS GOALS QUESTIONNAIRE

Today's Date: \_\_\_\_\_ Your Name: \_\_\_\_\_

In striving to achieve a higher state of health and fitness, a set of clearly articulated goals is essential. These goals will help guide your lifestyle choices such as when and what to eat, how often and how intensely to exercise, and how to overcome the challenges and barriers you will surely encounter.

## Please indicate your personal health and fitness goals:

*Circle Primary Goals*

*Check (✓) Secondary Goals*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> General Fitness                 | <input type="checkbox"/> Improve diet       | <input type="checkbox"/> ↓ Cholesterol         |
| <input type="checkbox"/> ↓ Weight: _____ lbs             | <input type="checkbox"/> Stop Smoking       | <input type="checkbox"/> ↓ Stress              |
| <input type="checkbox"/> Achieve ideal weight: _____ lbs | <input type="checkbox"/> Look Better: _____ | <input type="checkbox"/> ↑ Energy              |
| <input type="checkbox"/> ↓ Fat: _____ lbs                | <input type="checkbox"/> Feel Better        | <input type="checkbox"/> Sleep better          |
| <input type="checkbox"/> ↑ Muscle                        | <input type="checkbox"/> ↑ Self-esteem      | <input type="checkbox"/> Injury Rehab: _____   |
| <input type="checkbox"/> ↑ Strength / endurance          | <input type="checkbox"/> ↓ Pain: _____      | <input type="checkbox"/> Sport Specific: _____ |
| <input type="checkbox"/> ↑ Flexibility                   | <input type="checkbox"/> ↑ Balance          | <input type="checkbox"/> Other: _____          |

## Please answer the following questions:

1. **Why** have you decided to achieve these goals now? \_\_\_\_\_
2. **When** do you expect to reach these goals? \_\_\_\_\_
3. List any **barriers** to achieving your goals:
  - Financial:
  - Injuries:
  - Time limitations:
  - Lack of knowledge / Confidence:
  - Lack of motivation:
  - Health conditions:
4. What **time commitment** are you willing to invest to achieve your goals?
  - Time with personal trainer?
  - Time exercising on own?

Please use the space below to **record three (3) concrete commitments** that you are willing to make to achieve your above health and fitness goals. For example you might commit "To arrive, ready for exercise, on Monday, Wednesday, and Fridays by 4:30 pm." These should be challenging but also realistic and attainable commitments. When finished, please sign this form to signify your personal commitment.

## Three (3) Concrete Commitments to Reach Your Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Signed: \_\_\_\_\_ Witnessed: \_\_\_\_\_

# Exercise History & Interest Questionnaire

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_

## Recent Exercise Habits (within last 12 months):

What **type** of exercise do you do? \_\_\_\_\_

How many **times per week** do you currently exercise? \_\_\_\_\_

How many **times per week** during your exercise do you **break a sweat**? \_\_\_\_\_

On a scale from 1 to 10, how **intense** is your typical exercise? \_\_\_\_\_

Do you tend to **progressively "push"** yourself during exercise? YES NO SOMETIMES

Do your **muscles get sore / tender** after exercise? YES NO SOMETIMES

How **long** have you been doing this exercise consistently? \_\_\_\_\_

In a Typical Week, How Many Minutes Do You Spend in the Following Activities?

Running / Jogging _____	Walking _____
Aerobics _____	Hiking _____
Swimming _____	Racquet Sports _____
Biking _____	Skiing _____
Stair Climber _____	Yoga / Pilates _____
Weight Training _____	Other _____

## Past Exercise Habits:

How **long ago** did you do exercise on a **regular basis**? \_\_\_\_\_

What **type** of exercise did you do? \_\_\_\_\_

How many **times per week** did you exercise? \_\_\_\_\_

How many **times per week** during your exercise did you **break a sweat**? \_\_\_\_\_

On a scale from 1 to 10, how **intense** was your typical exercise session? \_\_\_\_\_

Did you tend to **progressively "push"** yourself during exercise? YES NO SOMETIMES

Did your **muscles get sore / tender** after exercise? YES NO SOMETIMES

How **long** did you exercise consistently? \_\_\_\_\_

## Place a Check Next to Your Activity Preference or Interest:

- |  |   |                                   |
|--|---|-----------------------------------|
| <input type="checkbox"/> Walking / Jogging / Running | <input type="checkbox"/> Martial Arts   | <input type="checkbox"/> Golf     |
| <input type="checkbox"/> Hiking                      | <input type="checkbox"/> Racquet Sports | <input type="checkbox"/> Skiing   |
| <input type="checkbox"/> Biking                      | <input type="checkbox"/> Yoga / Pilates | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Weight training             | <input type="checkbox"/> Kayaking       | <input type="checkbox"/> Other    |

# General Health Profile

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:     *Past 30 days*     *Past 48 hours*

<b>Point Scale</b>	0 <i>Never or almost never</i> have the symptom	3 <i>Frequently</i> have it, effect is <i>not severe</i>	4 <i>Frequently</i> have it, effect is <i>severe</i>
	1 <i>Occasionally</i> have it, effect is <i>not severe</i>		
	2 <i>Occasionally</i> have it, effect is <i>severe</i>		

**HEAD**

\_\_\_\_\_ Headaches

\_\_\_\_\_ Faintness

\_\_\_\_\_ Dizziness

\_\_\_\_\_ Insomnia

\_\_\_\_\_ **TOTAL**

**EYES**

\_\_\_\_\_ Watery or itchy eyes

\_\_\_\_\_ Swollen, reddened or sticky eyelids

\_\_\_\_\_ Bags or dark circles under eyes

\_\_\_\_\_ Blurred or tunnel vision  
(does not include near-  
or far-sightedness)

\_\_\_\_\_ **TOTAL**

**EARS**

\_\_\_\_\_ Itchy ears

\_\_\_\_\_ Earaches, ear infections

\_\_\_\_\_ Drainage from ear

\_\_\_\_\_ Ringing in ears, hearing loss

\_\_\_\_\_ **TOTAL**

**NOSE**

\_\_\_\_\_ Stuffy nose

\_\_\_\_\_ Sinus problems

\_\_\_\_\_ Hay fever

\_\_\_\_\_ Sneezing attacks

\_\_\_\_\_ Excessive mucus formation

\_\_\_\_\_ **TOTAL**

**MOUTH/  
THROAT**

\_\_\_\_\_ Chronic coughing

\_\_\_\_\_ Gagging, frequent need to clear throat

\_\_\_\_\_ Sore throat, hoarseness, loss of voice

\_\_\_\_\_ Swollen or discolored tongue, gums  
or lips

\_\_\_\_\_ Canker sores

\_\_\_\_\_ **TOTAL**

**SKIN**

\_\_\_\_\_ Acne

\_\_\_\_\_ Hives, rashes, dry skin

\_\_\_\_\_ Hair loss

\_\_\_\_\_ Flushing, hot flashes

\_\_\_\_\_ Excessive sweating

\_\_\_\_\_ **TOTAL**

**HEART**

\_\_\_\_\_ Irregular or skipped heartbeat

\_\_\_\_\_ Rapid or pounding heartbeat

\_\_\_\_\_ Chest pain

\_\_\_\_\_ **TOTAL**

**LUNGS**

\_\_\_\_\_ Chest congestion

\_\_\_\_\_ Asthma, bronchitis

\_\_\_\_\_ Shortness of breath

\_\_\_\_\_ Difficulty breathing

\_\_\_\_\_ **TOTAL**

**DIGESTIVE  
TRACT**

\_\_\_\_\_ Nausea, vomiting

\_\_\_\_\_ Diarrhea

\_\_\_\_\_ Constipation

\_\_\_\_\_ Bloating feeling

\_\_\_\_\_ Belching, passing gas

\_\_\_\_\_ Heartburn

\_\_\_\_\_ Intestinal/stomach pain

\_\_\_\_\_ **TOTAL**

**JOINTS/  
MUSCLE**

\_\_\_\_\_ Pain or aches in joints

\_\_\_\_\_ Arthritis

\_\_\_\_\_ Stiffness or limitation of movement

\_\_\_\_\_ Pain or aches in muscles

\_\_\_\_\_ Feeling of weakness or tiredness

\_\_\_\_\_ **TOTAL**

**WEIGHT**

\_\_\_\_\_ Binge eating/drinking

\_\_\_\_\_ Craving certain foods

\_\_\_\_\_ Excessive weight

\_\_\_\_\_ Compulsive eating

\_\_\_\_\_ Water retention

\_\_\_\_\_ Underweight

\_\_\_\_\_ **TOTAL**

**ENERGY/  
ACTIVITY**

\_\_\_\_\_ Fatigue, sluggishness

\_\_\_\_\_ Apathy, lethargy

\_\_\_\_\_ Hyperactivity

\_\_\_\_\_ Restlessness

\_\_\_\_\_ **TOTAL**

**MIND**

\_\_\_\_\_ Poor memory

\_\_\_\_\_ Confusion, poor comprehension

\_\_\_\_\_ Poor concentration

\_\_\_\_\_ Poor physical coordination

\_\_\_\_\_ Difficulty in making decisions

\_\_\_\_\_ Stuttering or stammering

\_\_\_\_\_ Slurred speech

\_\_\_\_\_ Learning disabilities

\_\_\_\_\_ **TOTAL**

**EMOTIONS**

\_\_\_\_\_ Mood swings

\_\_\_\_\_ Anxiety, fear, nervousness

\_\_\_\_\_ Anger, irritability, aggressiveness

\_\_\_\_\_ Depression

\_\_\_\_\_ **TOTAL**

**OTHER**

\_\_\_\_\_ Frequent illness

\_\_\_\_\_ Frequent or urgent urination

\_\_\_\_\_ Genital itch or discharge

\_\_\_\_\_ **TOTAL**

**GRAND TOTAL** \_\_\_\_\_

# PAR-Q and YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 to 69, the Par-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly. Check YES or NO.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<b>1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>2. Do you feel pain in your chest when you do physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>3. In the past month, have you had chest pain when you are not doing physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>4. Do you lose your balance because of dizziness or do you ever lose Consciousness?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>5. Do you have a bone or joint problem (for example, back, neck, knee, or hip) that could be made worse by a change in your physical activity?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>7. Do you know <u>any other reason</u> why you should not do physical activity?</b>

**if  
you  
answered**

## YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want—as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful to you.

## NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

## DELAY BECOMING MUCH MORE ACTIVE:

- If you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; **or**
- If you are or may be pregnant – talk to your doctor before you start becoming more active.

**PLEASE NOTE:** If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

**Informed use of the PAR-Q:** The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completion of this questionnaire, consult your doctor prior to physical activity.

**NOTE:** If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF PARENT: \_\_\_\_\_  
or GUARDIAN (for participants under the age of majority)

WITNESS: \_\_\_\_\_

**NOTE: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**



