FITNESS EVALUATION

(PLEASE PRINT THIS 2 PAGE FORM, COMPLETE ALL SECTIONS & RETURN TO PIF)

DATE: ____/____/____

FULL NAME: ____ AGE: _______

GENDER: ____________________ HEIGHT: ___________________ WEIGHT: ______________________

ADDRESS: ____

EMAIL ADDRESS: ___________________________________ PHONE NUMBER: ______________________

PIF OFFICE USE ONLY

RHR: ______________________ BP: ______________________ W/H RATIO: ______________________

HPH: _______________________ WPH: _______________________ MPH: _______________________

PRIMARY PHYSICIAN: ________________________________ PHONE NUMBER: ______________________

EMERGENCY CONTACT: ______________________________ PHONE NUMBER: ______________________

YOUR FITNESS GOALS: ____

____

SPORTS INTERESTS: ____

HEALTH RELATED QUESTIONS: (cross out the answer that does NOT apply e.g. YES/~~NO~~)

1) **Have you or anyone in your family been diagnosed with a heart condition? YES/NO**
2) **Do you experience shortness of breath? YES/NO**
3) **Do you have a lung condition? YES/NO**
4) **Do you have any back, neck or spinal problems? YES/NO**
5) **Do you experience any joint pain? YES/NO**
6) **Have you been recently hospitalized? YES/NO**
7) **Are you currently under a doctor's supervision? YES/NO**
8) **Are you taking prescription medications? YES/NO**
9) **When was your most recent physical exam? _______________**
10) **Were there any significant findings? YES/NO**
11) **Are you a smoker? YES/NO (If yes, how many? ____ cigarettes/day)**
12) **Do you consider yourself physically fit? YES/NO**

If you answered YES to any questions from 1-11, please provide details on Page 2 of this form.

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(PLEASE WRITE NEATLY OR TYPE HEALTH DETAILS IF REQUIRED)

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