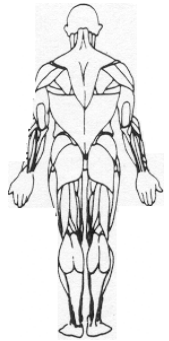


Personal Fitness Concepts

2311 Nelson Street
Richmond, Virginia 23228
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Carlos DeJesus Medical Exer-Therapist



"Connecting Health Care with fitness by assisting the Medical Community through the development of safe and effective exercise prescriptions for special population and post-rehab clients"

HEALTH ASSESSMENT

Name:

Email:

Skype:

PAST PERSONAL MEDICAL HISTORY/ If Checked Explain

Have you had/do you have?

Rheumatic Fever
Heart Murmur
High Blood Pressure
Heart Attack
Irregular Heart Rate
Chest Pain
Abnormal EKG
Artery Disease
Varicose Veins
Lung Disease
Epilepsy
Diabetes
Stroke

FAMILY MEDICAL HISTORY/ If Checked Explain

Has anyone in your family had?

Heart Attack before age 50
Heart Operations
High Blood Pressure
High Cholesterol
Diabetes
Coronary Heart Disease
Other

PRESENT STATUS/ If Checked Explain

Do you have?

Chest Pain

Shortness Of Breath

Heart Palpitations

Lightheadedness

Cough On Exertion

Coughing Up Blood

Back Pain

Joint Stiffness

Diabetic

Surgery

Allergies or Asthma

Hernia

Headaches

Accidents or Injuries

Arthritis

Emphysema

Frequent Colds

Vision Disorders

Faint or Dizzy

STATISTICAL FACTORS

Age:

Height:

Weight:

Resting Heart Rate:

Date of last physical:

Blood Pressure:

Blood Cholesterol:

Stress Level:

Extreme

Moderate

Low

Do you actively attempt to control your level of stress?

Yes No

How?

Do you smoke?

Yes No

Have but quit Yes No

Cigarettes Cigar Pipe How many years

What is your alcohol intake?

Is your primary occupation?

Sedentary Inactive Active Heavy

What is your Occupation(s)?

How far do you walk each day?

Realistically, how much time daily can you devote to an exercise program?

Are you under the care of a physician for any injury or chronic condition? Please explain if yes.

Are you currently participating in an exercise program?

Is it supervised?

Please describe your current program.

Do you feel that it failed?

What kind of difficulty have you had being compliant with the program?

When exercising have you ever experienced:

Shortness of breath Chest pain Joint Discomfort Lower Back Pain I do not exercise

NUTRITION

List the previous two days of food consumption

Meal 1:

Meal 2:

Meal 3:

Meal 4:

Meal 5:

Meal 6:

Do you desire help with nutrition? Yes No

Do you want to Lose body fat Gain muscle mass Gain Strength

Are you currently using any nutritional supplements?

Which?

Are you taking any prescribed or unprescribed medication?

Which?

Number of hours you sleep per 24?

Have you ever used free weights?

For how long?

Have you ever attended an aerobics class or performed aerobic exercises?

Do you feel that there are any other details that would help determine the proper preparation of an exercise prescription for you; broken bones, muscle strains or sprains, dislocations, knee, joint, kidney or circulation problems?

How would you assess your present physical condition?

What are your goals? What do you wish to accomplish?

Why?

What is your favorite movie or book?

Why?

What type of exercise equipment do you have access to?

What do you believe has kept you from realizing your fitness/health goals?

How would you define my role in helping you achieve your fitness/health goals? What kind of accountability are you needing/looking for?