Personal Training Academy

The Professional's Choice

Health Screen Form

Personal Information

Date _____

Name: _____

Address: _____

Contact Phone numbers: HM: _____ MOB: _____

Occupation _____

DOB: _____ Age: _____

Health History

Have you had a general medical check up in the last 6 months? YES NO

Who is your family doctor? _____

Have you ever been told by your doctor to avoid any type of exercise or strenuous physical activity? YES NO

If yes, please elaborate: _____

Do you have Type 1 OR 2 diabetes? YES NO

If YES, please give details; _____

_____

_____

Does anyone in your family have a history of the following conditions?

Heart attacks ☐ Myocardial Infarction ☐ Stroke ☐
Angina ☐ Any Cardiac Conditions ☐

If YES, please give details; _____

_____

Are you on blood pressure medication? YES NO

If YES please list; _____

Are you currently on any medications that could influence your ability to exercise? YES NO

If YES, please state; _____

_____

_____

_____

Do you have any allergies or medical conditions or any other circumstances that could influence your ability to exercise? YES NO

If YES, please explain;_____

_____

Are you a current smoker? YES NO

Were you previously a smoker? YES NO

If you are currently smoking, how many would you have a day?_____

Do you drink alcohol? YES NO

If yes, how many standard drinks would you have in an average week?_____

What best describes your weight history for the last 12 months?

Stable ☐ Fluctuating ☐ Increasing ☐ Decreasing ☐☐

Has doctor or family member raised your weight as a medical issue? YES NO

Injury History

Do you have any current injuries? YES NO

If YES, please state;_____

_____

_____

Do you have a history of any injuries related to?

Soft tissue	Head	Neck	Shoulder
Trunk	Lower Back	Upper Back	Hip
Knee	Ankle	Elbows	Feet

Please give details;_____

_____

_____

Are you currently physically active? YES NO

If YES, please give details; _____

Do you currently participate in sport? YES NO

If yes, which sport?_____

Dietary Information

Are you aware of what constitutes a healthy diet? YES NO

Have you heard of any of these dietary guidelines/models before?

- Healthy Eating Pyramid ☐
- 50% CHO, 30% FAT, 20% PRO ☐
- 2 Fruits, 5 Vegetables a day ☐
- Low GI diets ☐
- Low carbohydrates, High protein diets ☐

Do you presently eat a healthy well balanced diet? YES NO

Do you believe you have any problems with your present diet? YES NO

If YES, please describe;_____

_____

_____

Do you drink tea or coffee regularly? YES NO

If YES, how many cups a day?_____

How much water do you drink daily?

1-2 glasses ☐ 3-4 glasses ☐
5-6 glasses ☐ 7-8 glasses ☐ Litres consumed per day?_____

Needs Analysis

List from 1-5 the importance of these health and fitness components, with 5 being weighted as very important. (please circle)

Aerobic capacity	1	2	3	4	5
Anaerobic capacity	1	2	3	4	5
Strength	1	2	3	4	5
Muscular endurance	1	2	3	4	5
Muscular power	1	2	3	4	5
Posture	1	2	3	4	5
Body composition	1	2	3	4	5
Flexibility	1	2	3	4	5
Agility	1	2	3	4	5
Weight Loss	1	2	3	4	5

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Goal Setting

_____

_____

_____

_____

Physical Conditioning

MEASUREMENTS

Date					
Blood Pressure					
Resting HR					
Predicted Max HR					
Height (m)					
Weight (kg)					
BMI (W/H^2)					

GIRTHS

Body Part	Date:		Date:		Date:	
Biceps	**R**	**L**	**R**	**L**	**R**	**L**
Forearm	**R**	**L**	**R**	**L**	**R**	**L**
Chest						
Waist						
Hips						
Waist : Hip Ratio						
Gluteus						
Thigh	**R**	**L**	**R**	**L**	**R**	**L**
Calf	**R**	**L**	**R**	**L**	**R**	**L**

SKINFOLDS

SKINFOLD	Date:	Date:	Date:
Bicep			
Triceps			
Sub scapular			
Supra spinale			
Abdominal			
Mid thigh			
Calf			
Sum of skin folds			
Estimated body fat			