ADULT personal fitness profile

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Date _____ **Appointment Date** _____

Name _____ **Preferred time for appointment** _____

Mailing Address _____

_____

E-mail address _____ **Home Phone** _____ **Work Phone** _____

Date of Birth _____ **Age** _____ **Gender** _____ **Height** _____ **Weight** _____

Occupation _____ **Primary Physician & Phone** _____

IN CASE OF EMERGENCY CONTACT:
Name _____ Phone _____

The Waldo County YMCA recommends that all individuals consult their physician prior to beginning a new exercise program.

None of the following questions are for diagnostic or treatment purposes. Mark all true statements.

History: *You have had:*

□ a heart attack
□ heart surgery
□ cardiac catheterization
□ coronary angioplasty (PTCA)
□ pacemaker / implantable cardiac
□ defibrillator / rhythm disturbance
□ heart valve disease
□ heart failure
□ heart transplantation
□ congenital heart disease
□ stroke
□ embolism or aneurysm
□ angina pectoris

If you have marked any of the statements in this section, we will need to have medical clearance prior to our scheduling a fitness orientation. The **Physician Clearance Form** is available at the front desk. This form requires your signature and your physician's name, address, and phone number. When we receive this information, we will fax the form to your healthcare provider. In most cases they are returned within 24 hours.

We aim to make your exercise experience to be as safe as possible. The information your physician provides can be invaluable when creating a safe exercise program.

Symptoms

□ You experience chest discomfort with exertion.
□ You experience unreasonable breathlessness
□ You experience dizziness, fainting, and/or blackouts.
□ You take heart medications.

Other health issues

□ You have musculoskeletal problems. Problems with:
□ Shoulder(s) □ Neck □ Back □ Hip(s) □ Knee(s) □ Ankle(s) □ Other _____
Please describe: _____
□ You are pregnant. If yes, check w/ your physician before beginning an exercise program. **Due date:** _____

□ Asthma
□ Thyroid problems
□ Emphysema
□ Phlebitis
□ Chronic bronchitis
□ Peripheral vascular disease
□ Claudication

~please complete the other side of this page!

Cardiovascular risk factors

□ You are a man older than 45 years.
□ You are a woman older than 55 years or you have had a hysterectomy or you are postmenopausal.
□ You smoke, or have smoked in the past 6 months.
□ Your blood pressure is greater than 140/90 mm Hg.
□ You don't know your blood pressure.
□ You take blood pressure medication.
□ Your blood cholesterol level in greater than 240mg/dl.
□ You don't know your cholesterol level.
□ You have a blood relative who has had a heart attack *before age 55 (father/brother) or 65 (mother/sister).*
□ You are diabetic or take medicine to control your blood sugar.
□ You are physically inactive *(i.e., you get less than 30 minutes of physical activity on at least 3 days/week.)*
□ You are more than 20 pounds overweight.

If you have marked two or more of the statements in this section, you should consult your physician before beginning a new exercise program.

1) Are you presently taking medication? □ Yes □ No
If yes, give name and dosage. You may attach an additional sheet if necessary.

2) Have you had any recent surgery? □ Yes □ No
If yes, describe: _____

3) What is your present level of physical activity?_____
□ Sedentary □ Active lifestyle □ Currently exercising □ Athlete

4) If you currently exercise, what exercise activities does your workout include?
_____
_____

5) What are your short and long term goals for exercise, health, and fitness?
□ Weight loss □ Health/wellness □ General strength □ Bodybuilding □ Sculpting
□ Cardiovascular endurance □ Flexibility □ Sport specific □ Stress reduction □ Other
Short term: _____
Long term: _____

6) Are you presently on a special diet? □ Yes □ No
If yes, please describe: _____
_____

7) Do you have any physical condition that might affect your ability to undertake an exercise program?
□ Yes □ No If yes, please explain: _____

Signature _____ Date _____

Parent/Guardian's signature required if under 18 years of age _____

TO BE COMPLETED BY TRAINER: Blood Pressure _____ Resting Heart Rate _____

Percentages ____ - ____ THRZ_____ Beats/ 10 sec. _____

Trainer _____ Date _____

WALDO COUNTY YMCA
157 Lincolnville Avenue
Belfast, Maine 04915
207.338.4598 WWW.WALDOCOUNTYYMCA.ORG
e-mail: fitness@waldocountyymca.org