



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 Chronic bronchitis
- Thyroid problems Peripheral vascular disease
- Emphysema Claudication
- Phlebitis

~ 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 is 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 _____
Trainer _____	Date _____	