



CLIENT INFORMATION

NAME _____ DOB ____ / ____ / ____ FEMALE ____ MALE ____ GRADE ____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 CELL PHONE _____ EVENING PHONE _____ EMAIL _____
 PARENT'S NAME (For Youth Clients only) _____
 EMERGENCY CONTACT _____ PHONE NUMBER _____ RELATIONSHIP _____
 PHYSICIAN'S NAME _____ PHONE NUMBER _____ FAX _____

PHYSICAL ACTIVITY and READINESS QUESTIONNAIRE (Check Yes or no)

- Has a physician ever said the client has a heart condition and recommended only supervised activity? Yes No
 - Has a physician ever recommended medication for the client's heart? Yes No
 - Does the client have exercise or activity induced asthma? Yes No
 - Does the client have a bone or joint problem that could be aggravated by the proposed physical activity? Yes No
 - Are you aware, through your own experiences or a physician's advice, of any other physical reason why the client should not exercise without medical supervision? Yes No
- If you answered YES to any of the above, please answer the following:
- Have you consulted you physician regarding increasing the client's physical activity and or performing a fitness assessment? Yes No
 - If you answered NO to question 6, will you consult your physician prior to increasing the client's physical activity and/or performing a fitness assessment Yes No

Heart Condition: Yes No Duration: _____ **Rheumatism:** Yes No Duration: _____
Diabetes: Yes No Duration: _____ **Hernia:** Yes No Date: _____
Arthritis/Bursitis: Yes No Duration: _____ **Recent Surgery:** Yes No Date: _____
High Blood Pressure: Yes No Duration: _____ **Knee Problems:** Yes No Duration: _____
Back Problems: Yes No Duration: _____

Please List Other (Physical/Emotional/Behavioral/Psychological):

FITNESS HISTORY

- Has the client ever been a participant in an organized fitness program? Yes No
 If yes, where and duration: _____
- Is the client currently involved in a fitness program or sport outside of Academy 44? Yes No
 If yes, please list all (and duration) if you are training with Academy 44: _____

GOALS

- What are your primary fitness goals? General Conditioning..... Sports Performance..... Weight Management (↑ or ↓) _____
 Balance/Coordination..... Strength Training..... Cardiovascular..... Other _____
- How often would you like to see your progress measured? Every:..... 1 month..... 3 months..... Other _____
- On a scale from 1 to 10, 10 being the highest, how committed are you to completing your goal(s)? _____

I certify that the above statements are true and correct. I understand that a physician's note may be requested. If a note is requested, I should not proceed with this workout until the note is received.

Client/Parent/Legal Guardian

Signature: _____ Date: _____