All About You Wellness Boot Camp Fitness Assessment

Last Name:____________________________First Name: _____________________
Street Address: ____
City: _________________________________Zip Code: _______________________
Phone (Home): _________________________Phone (Work): ___________________
Phone (Cell): __________________________E-Mail: _________________________
Birthday: ______________Emergency contact name & number:________________________

Please take a moment to answer the following questions:

Questions	**Yes**	**No**
Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
Do you feel pain in your chest when you perform physical activity?		
In the past month, have you had chest pain when you were not performing any physical activity?		
Do you lose your balance because of dizziness or do you ever lose consciousness?		
Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
Is your doctor currently prescribing any medication for your blood pressure, for a heart condition or for any other reason?		
Do you know of any other reason why you should not engage in physical activity?		

Have you ever had or do you currently have:	**Yes**	**No**
Asthma		
Extensive Back Problems		
Knee or Shoulder Problems		
Bronchitis		
Depression		
Arthritis		
Hypoglycemia		
Hypo or Hyperthyroidism		
Diabetes		
High Cholesterol		
Anxiety/ Panic Attacks		
PMS		
Currently Pregnant		
Any major surgery or illness		
Other:		

If you marked **Yes** for any of the above questions, please explain: ____________________
____

Lifestyle Questions

Occupation

1. What is your current occupation?______________________________
2. Does your occupation require extended periods of sitting?______________________
3. Does your occupation require extended periods of repetitive movements?________
   If Yes, please explain:____
4. Does your occupation require you to wear dress shoes?_________________________
5. Does your occupation cause you anxiety or mental stress?______________________

Recreation

1. Do you partake in any recreational activities (golf, tennis, skiing, etc.)?__________
   ____
2. Do you have any hobbies (reading, gardening, working on cars)? _______________
   ____
3. Do you smoke cigarettes or cigars? If so, how much?__________________________
4. Do you drink alcoholic or caffeinated beverages? If so, how much?_____________

Nutrition

1. Describe what you eat and drink on a typical work day:________________________
   ____
   ____
   ____
2. Describe what you eat and drink on the weekends:_____________________________
   ____
   ____
   ____
3. What do you feel is your biggest downfall regarding nutrition?________________
   ____

Exercise History and Fitness Goals

1. Describe any physical activities you have been involved with in the past or currently.____
   ____
2. Are you interested in weight loss? If so, how many pounds?__________________
3. What methods have you used to try to lose weight and how effective have they been?____
   ____
4. What other fitness goals do you have? Think about what you want to look like, how you want to feel and what you want to be able to do._____________________
   ____
5. On a scale of 1-10 how important is it to you to achieve your fitness goals?_______
6. On a scale of 1-10 how COMMITTED are you to achieving your fitness goals?____