



TOTAL HEALTH CONCEPTS, INC.
(703) 255-7012 / FAX (703) 255-6171

Nutrition, Fitness, and Psychotherapy Professional Services

Please Print Clearly

FITNESS ASSESSMENT FORM

Date ___ / ___ / ___

Last Name _____ First Name _____ Initial _____
Address: _____ State _____ Zip _____
Home Phone: _____ Cell: _____ Work: _____
Email Address: _____
Date of Birth: _____ Age: _____
Sex: M/F Height: _____ Weight: _____
Occupation: _____

Please fill in the names and phone numbers of the professionals from whom you are currently receiving treatment

Physician:	Phone:
_____	_____
Psychiatrist:	Phone:
_____	_____
Therapist/Psychologist:	Phone:
_____	_____
Nutritionist:	Phone:
_____	_____
Other:	Phone:
_____	_____

Who referred you to Total Health Concepts?

Medical Diagnosis/ Primary Concerns or Problems _____

Physical Health Profile

Please check all that apply.

You have had:

- Heart Attack
- Heart Surgery
- Cardiac Catheterization
- Coronary Angioplasty (PTCA)
- Pacemaker-implantable cardiac
- Defibrillatory/Rhythm Disturbance
- Heart Valve Disease
- Heart Failure
- Heart Transplantation
- Congenital Heart Disease
- Diabetes
- Asthma / Other Lung Disease

Have you ever experienced any of the following?

- Pain/tightness in chest or surrounding areas
- Rapid beating of your heart or skipping of heartbeats
- Painful burning or cramping pain in legs/feet
- Extremely swollen feet/ankles (other than after a long period of standing)
- Feeling unusually fatigued or difficult to breathe with usual activities
- Feeling faint or dizzy (other than when sitting up rapidly)
- Difficulty breathing when lying down or sleeping
- A physician has said you have a heart murmur

Are you taking heart medications? _____

Are you taking any other prescription medications? _____

Do you have any of the following?

- Arthritis
- Bursitis
- Disc problems / low back pain
- Torn ligament / sprain
- Torn muscle or tendon / strain
- Muscle soreness that limits activity
- Surgery: _____
- Physical impairment: _____
- Previous or current injuries: _____

Are you pregnant? _____

If you marked any statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. Please complete a physician's consent form and bring it with you to your first session.

Risk Factors Profile

Check all statements that apply to you:

- You are a man older than 45 years
- You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal
- You smoke, or quit smoking within the previous 6 months
- Your blood pressure is > 140 / 90 mm Hg
- You do not know your blood pressure
- You take blood pressure medication
- Your LDL cholesterol level is > 130 mg/dL or HDL is <40 mg/dL (or your total cholesterol level is >200mg/dL.
- You do not know your cholesterol levels
- You have a close blood relative who had a heart attack, bypass surgery, angioplasty or cardiac sudden death before age 55 (father or brother) or age 65 (mother or sister)
- You are physically inactive (i.e. you get < 30 minutes of activity on most days)
- You have a Body Mass Index ≥ 30 or your waist girth is >40 inches (m) or >35 inches (f)

If you marked two or more of the statements in this section, consult your physician or other healthcare provider before engaging in exercise. Please complete a physician's consent form and bring it with you to your first session.

Exercise and Goals Profile

Current Injuries/Problem Areas:

- | | | | |
|-------------------------------|---------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Back | <input type="checkbox"/> Knees | <input type="checkbox"/> Feet | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Elbows | <input type="checkbox"/> Hips | <input type="checkbox"/> Ankles |

Describe: _____

Other: _____

Do you wear any type of arch support or orthotic? _____

Exercise Goals:

- | | | |
|---|--|--|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Posture/Balance | <input type="checkbox"/> Strength |
| <input type="checkbox"/> Flexibility/Stretching | <input type="checkbox"/> Endurance | <input type="checkbox"/> Sports Specific |

Specify: _____

Other: _____

Are you currently involved in a regular exercise program?

- | | | | |
|--|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Running | <input type="checkbox"/> Biking | <input type="checkbox"/> Cross-trainer |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Dance | <input type="checkbox"/> Martial Arts | <input type="checkbox"/> Yoga/Pilates |
| <input type="checkbox"/> Weight training | <input type="checkbox"/> Stretching | | |

Other: _____
Number times per week: _____ Minutes per session: _____

What activities do you prefer?

_____ Walking _____ Running _____ Biking _____ Cross-trainer
_____ Swimming _____ Dance _____ Martial Arts _____ Yoga/Pilates
_____ Weight training _____ Stretching

Other: _____

What setting do you prefer?

_____ Health Club _____ Office _____ Home
_____ Indoors _____ Outdoors

Other: _____

What time of day do you prefer?

_____ Early AM _____ Mid AM _____ Midday
_____ Afternoon _____ Evening

Other: _____

What barriers to regular exercise have you experienced?

_____ No time _____ Associate exercise with diet/weight _____ Hate sweating
_____ Need to look good to exercise _____ Is a "should" not a "want"
_____ Don't know what to do _____ Chronic pain / muscle soreness

Other: _____

What activities might make exercising more enjoyable for you?

_____ Music _____ Reading _____ TV
_____ Company / Social Environment

Other: _____