Main Street, Dunedin, FL 34698
727-282-1800 | Fax: 727-469-8923

# Initial Medical & Fitness Screening Form

## A. Personal Information

Last Name | First Name | MI | Birth Date | Sex

Street Address | City | Zip Code

Cell Phone | Home Phone | Work Phone | Occupation

Is Florida your permanent address? If not, what months and where do you reside elsewhere?

Email | Cell Phone (if different) | Mobile Provider

Preferred Contact Method: ◯ TEXT & EMAIL ◯ EMAIL ONLY ◯ TEXT ONLY

In Case of Emergency, Contact: | Relationship | Phone

How Did You Hear About Rock Solid Fitness? | Date of Last Physical Exam

## B. Past Operations and Dates

## C. Have you participated In Physical Therapy? ◯ YES ◯ NO

## D. List any medication you are on or currently taking:

| Type of Medication | Dosage | Reasons for Taking |
|---|---|---|
| | | |
| | | |
| | | |

## E. Are you allergic to any medications? ◯ YES ◯ NO | If YES, please list:

## F. Indicate any injuries, past or present, or limitations that may affect your training program.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Foot:** | Left ☐ | Right ☐ | **Wrist:** | Left ☐ | Right ☐ | **Abdominal:** ☐ | | |
| **Ankle:** | Left ☐ | Right ☐ | **Elbow:** | Left ☐ | Right ☐ | **Neck:** ☐ | | |
| **Knee:** | Left ☐ | Right ☐ | **Shoulder:** | Left ☐ | Right ☐ | **Back:** ☐ | | |
| **Hip:** | Left ☐ | Right ☐ | **Hand:** | Left ☐ | Right ☐ | | | |

**G. Personal/Family History**

Please check all boxes that apply to you. If you checked a symptom box please elaborate. Also, please indicate if the condition occurs in your immediate family.

- ☐ High Blood Pressure
- ☐ Heart Attack or Stroke
- ☐ Cigarette Smoke
- ☐ Diabetes
- ☐ High Cholesterol Levels
- ☐ Asthma
- ☐ Eating Disorder
- ☐ Obesity
- ☐ Cancer
- ☐ Hernia
- ☐ Arthritis
- ☐ Thyroid Conditions
- ☐ Gait Problems
- ☐ Head Injury/Concussion
- ☐ Pregnant
- ☐ Osteoporosis

**H. Please indicate your exercise level:**

| Activity | Times Per Day | Days Per Week |
|---|---|---|
| | | |
| | | |
| | | |

**I. If you could have the ideal personal trainer, what would they be like and how would they motivate you?**

If something will contribute to you missing workouts or being inconsistent with workouts, what do you expect it will be?

**J. Indicate special goals you may have regarding your fitness program.**

1.
2.
3.

**K. What is your <u>primary</u> reason for strength training?**

◯ Increased Energy ◯ Increased Focus ◯ Better Sleep ◯ Stronger Immune System ◯ Manage Stress ◯ Better Mood
◯ Mental Health ◯ Improved Cognition & Memory ◯ Self Discovery ◯ Other:

**L. What is your <u>primary</u> reason for training with a personal trainer?**

◯ Not Sure What To Do On My Own ◯ Not Seeing Results On My Own ◯ Extra Motivation ◯ Accountability ◯ Safety
◯ Learn More About Strength Training ◯ Personalized Fitness Plan ◯ Make Exercise More Fun ◯ Need To Be Challenged
◯ Have Progress Recorded ◯ Other:

**M. What do you require to make sure you have a great day? (i.e. sleep, exercise, meditation, etc.)**

**N. Putting myself and my needs before others is:** ◯ Something I practice daily ◯ Something I feel selfish doing

**O. How would you rate the quality of your sleep each night? (1 being tossing and turning all night, and 10 being sleeping like a baby)** ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

How would you rate your energy level throughout the day? (1 being always tired, and 10 being full of energy)

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

How would you rate your ability to handle your stress? (1 being bogged down by stress, and 10 being unaffected by stress)

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

How would you rate the aches and pains you experience daily? (1 being no aches/pains and 10 being constantly aching/in pain)

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

How much anxiety do you experience daily? (1 being none and 10 being constantly anxious)

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

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**P. How often do you eat breakfast & how long after you wake up?**

**Q. How much water do you drink everyday & how do you track it?**

**R. How many calories do you eat every day & how do you track it?**

**S. How often do you drink alcohol?**

**T. How often do you cook & how often do you go out to eat?**

**U. How many meals per day do you eat?**

**V. Do you try to avoid anything in your diet?**

**W. What nutrition information do you find confusing or conflicting?**

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**X. What genre of music do you like to listen to while working out?**

☐ Funk ☐ Rock ☐ Pop 80's-90's ☐ Today's Hits ☐ Dance ☐ Oldies

Give an example of a Band/Artist you enjoy:

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**Rock Solid Fitness Cancellation Policy**

**We have a Day Before cancellation policy.** If you need to cancel or reschedule an appointment, please notify us by **8PM THE DAY BEFORE** your appointment. **Cancellations after 8pm the day prior to appointment will result in an additional $25 fee.**

By signing below, I verify that the information provided to Rock Solid Fitness is accurate to the best of my knowledge. I have read and understand the above questions regarding my health status. I was given sufficient opportunity to ask questions about the information contained in this document, my health status, and how exercise affects my health. I also acknowledge that I have read and understand the Rock Solid Fitness cancellation policy.

Client Signature: Date:

Parent/Guardian Signature: Date:

Instructor Signature: Date: