

ROCK SOLID FITNESS

2110 Main Street, Dunedin, FL 34698
727-282-1800 Fax- 727-408-5019

Initial Medical and Fitness Screening Form

Personal Information

Last Name	First	MI	Birth Date	Sex
Street Address	City		Zip	
Cell Phone	Home Phone	Work Phone	Occupation	

Is Florida your permanent address?

Yes

No – Please list secondary address and duration spent there down below.

Email Address: _____

Contact Method Preferred:

TEXT & EMAIL

EMAIL ONLY

TEXT ONLY

PHONE CALL

In Case of Emergency, Contact: _____

Relationship: _____ Telephone: _____

How Did You Hear About Rock Solid Fitness FL? _____

Date of last physical exam: _____

Indicate any injuries, past or present, or limitations that may affect your training program
(please be as specific as possible):

Past Operations and Dates:

Have you participated in Physical Therapy? Y or N If Yes, What for?

List any medication you have been on, or are currently taking and what it is for:

Are you allergic to any medications? No Yes

If yes, please list: _____

Personal History

Please check the column opposite each condition if it applies to you.

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack or Stroke | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Cigarette Smoke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Conditions |
| <input type="checkbox"/> High Cholesterol Levels | <input type="checkbox"/> Gait Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury/Concussion |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Osteoporosis |

Please indicate your present exercise activity level:

Activity	Times Per Day	Days Per Week

How do you want your Fitness Coach to show up for you/ how would they motivate you?

Indicate specific goals you may have regarding your fitness program:

1. _____
2. _____
3. _____

Please circle your primary reason for strength training:

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

Other: _____

Please circle your primary reason for training with a personal trainer:

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

Other: _____

If participating in our Virtual Training, please circle an equipment option below and location in which you will be exercising.

Equipment

- a. Rock Solid Fitness equipment box (yoga strap, resistance bands, exercise ball and pump)
- b. My own equipment (please indicate what you have and email photos):

Location

- a. My own home
- b. A fitness facility or gym I have access to (please indicate what you will have and email photos)

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

Putting myself and my needs before others is:

- a) Something I practice daily
- b) Something I feel selfish doing

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 constantly aching/in pain and 10 being no aches or pains.

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

How often do you eat breakfast? _____

How long after you wake up do you eat breakfast? _____

How much water do you drink every day? _____

How do you know/track that? _____

How many calories do you eat every day? _____

How do you know/track that? _____

How often do you drink alcohol? _____

How often do you cook? _____

How often do you go out to eat? _____

How many meals per day do you eat? _____

Do you try to avoid anything in your diet? _____

What nutrition information do you find confusing or conflicting?

Do you give Rock Solid Fitness permission to share your success?

- Yes – Internally only (In studio only)
- Yes – Internally & Externally (In studio, social media, website, etc.)
- No – I do not give Rock Solid Fitness permission to share my success anywhere

Rock Solid 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 may result in loss of the appointment or a \$25 rescheduling 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, agreement to participate and waiver of liability policies.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Instructor Signature: _____ Date: _____