Tools-4-Life
Integrated Wellness Training Profile

PERSONAL INFORMATION

Name:____ Age: ____ Male ___ Female ____

Address: ________________________________ City: ______________________ Zip: ____________

Evening Phone: _________________________ Email: ______________________________________

Emergency Contact:_______________________________ Phone: ____________________________

Physician Information: _____________________________ Phone: ____________________________

FITNESS GOALS

Improve Health: ____

Weight Loss: ____

Improve Health: ____

Tone & Firm: ____

Build Muscle: ____

Other (explain): ____

LIFESTYLE

Hobbies: ____

Sports experience: ____

OCCUPATION

Current occupation: ____

Does your occupation force you to sit or stand for long periods of time? YES/ NO

Does your occupation require extended periods of repetitive movements? YES/ NO

Please describe: ____

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

1. Has a doctor said that you have a heart problem? YES / NO
2. Do you frequently suffer from in your chest? YES / NO
3. Do you often feel faint or have spells of severe dizziness? YES / NO
4. Has your doctor told you that your blood pressure is high? YES / NO
5. Has your doctor told you that you have bone or joint problems, such as arthritis that has been aggravated or made worse by exercise? YES / NO
6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to? YES / NO
7. Are you 65 or older and not accustomed to vigorous exercise? YES / NO

IF YOU ANSWERED YES TO ANY QUESTION ABOVE:

8. Have you consulted with your physician regarding increasing your physical activity and/or having a fitness evaluation? INITIAL: _____________ YES / NO

IF YOU HAVE ANSWERED NO TO QUESTION 8:

9. Will you consult with your physician prior to increasing your physical activity and/or take a fitness evaluation? YES / NO

Do you suffer from any of the following conditions:

Heart condition	YES/NO
Diabetes	YES/NO
Asthma	YES/NO
Shortness of Breath	YES/NO
Arthritis/ Bursitis	YES/NO
Rheumatism	YES/NO
Hernia	YES/NO
Recent Surgery	YES/NO
Sacroiliac Problems	YES/NO
Knee Problems	YES/NO
Back Problems	YES/NO
Hip problems	YES/NO
Do you smoke?	YES/NO
Do you take any medications?	YES/NO

List Medications: ____

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