Testing and Evaluation

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Leslie Salmon's Fitness Training Program

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Please fill out this form as complete as possible. If you have any questions, please do not hesitate to ask.

Date: ______________________________

Name: ______________________________ **Date of Birth:** __________________

Address: ____

Telephone (Home): ____

Telephone (Business): ____

Email Address: ____

Personal Physician: ____

Physician's Address: ____

Physician's Telephone: ____

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1. **Please rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each range through your present age:**

   15-20 ____ 21-30 ____ 31-40 ____ 41-50+ ____

2. **Were you a high school and/or college athlete?**

   Yes ____ No ____

3. **Do you have any negative feelings toward or have you had any bad experience with physical activity programs?**

   Yes ____ No ____

4. Do you have any negative feelings toward or have you had any bad experience with fitness testing and evaluation?

Yes ____ No ____

If yes, please explain: ____

5. Rate yourself on a scale of 1 to 5 (1 indicating the lowest value and 5 the highest).

Circle the number that applies the most.

Characterize your present athletic ability:

1 2 3 4 5

When you exercise, how important is competition?

1 2 3 4 5

Characterize your present cardiovascular capacity:

1 2 3 4 5

Characterize your present muscular capacity:

1 2 3 4 5

Characterize your present flexibility capacity:

1 2 3 4 5

6. Do you start exercise programs but then find yourself unable to stick with them?

Yes _____ No _____

7. How much are you willing to devote to an exercise program?

Minutes/days ________ days/weeks _________

8. Are you currently involved in regular endurance (cardiovascular) exercise?

Yes _____ No _____ if yes; specify the type of exercise(s) ________________________

Rate your perception of the exertion of your exercise program (circle the number):

(1) Light (2) Fairly light (3) Somewhat hard (4) Hard

9. How long have you been exercising regularly?

________ months _______ years

10. What other exercise, sport, or recreational activities have you participated in?

In the past 6 months? ____

In the past 5 years? ____

11. Can you exercise during your workday?

Yes ______ No _______

12. Would an exercise program interfere with your job?

Yes ______ No _______

13. Would an exercise program benefit your job?

Yes ______ No _______

14. What types of exercise interest you?

Walking___________________ **Stationing Biking____________**

Jogging___________________ **Rowing_____________________**

Swimming_________________ **Racquetball_________________**

Cycling____________________ **Tennis______________________**

Dance exercise______________ **Other aerobic________________**

Strength training____________ **Stretching___________________**

Additional comments and/or questions:

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____

Medical History:

Are you currently using any medications? ____

Have you had any operations? ____

If yes please explain. ____

Do you or your family have a history of: ____

Heart Problem ____

Asthma ____

Hypertension ____

Stroke ____

High Blood Pressure ____

High Cholesterol ____

Back Pain ____

Diabetes ____

Other ____

Do you have any injuries, if so please specify?

____

____

Do you smoke? ____________

Do you drink alcohol? ________________

Do you take nutritional supplements? ____

Are you on any special diet? ____