Lindi Fitness

PERSONAL TRAINING FITNESS ASSESSMENT

Name	Gender	DOB
Emergency Contact		
Height	Weight	Body Fat
Measurements:		
Biceps	Upper Thigh	Mid Thigh
Buttocks	Hips	Waist
Chest	Calves	
Right/left handed		

Posture	Body Type
Parental Body Type	Weight Loss Desired
Problem Areas	Resting Heart Rate
Current Daily Calorie Intake	Calories required to maintain weight
Calories required to lose weight	

Current Exercise Regime including intensity
Current level of fitness
Food preferences/pattern of eating
What food do you dislike?
How do you relax and how often?

MEDICAL INFORMATION

GP Name and Contact Details		
Are you currently under the care of GP or hospital? If so, why?		
Have you ever been advised not to exercise?		
Current Medication		
Current Supplements Taken		
Do you smoke? Yes/No	Are you pregnant? Yes/No	Units of alcohol drunk per week