

**Be Fit Anywhere, LLC  
Client Profile History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Mobile) \_\_\_\_\_

Email: \_\_\_\_\_

<p><b>To be completed by BFA:</b></p> <p><b>Doctor Clearance Required?</b></p> <p><b>YES / NO</b></p>
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<b>Emergency Contact Information:</b>
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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I am currently physically active at (at least 30 minutes per week)	Yes	No
I intend to become more physically active in the next 6 months	Yes	No
I currently engage in <b>regular</b> physical activity	Yes	No
I have been <b>regularly</b> physically active for the past 6 months	Yes	No

On average, how many day per week do you engage in moderate to strenuous exercise (like a brisk walk)? \_\_\_\_\_

On average, how many minutes do you engage in exercise at this level? \_\_\_\_\_

<b>Section 1 - General Health</b>
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Regular physical activity is fun and healthy and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly:

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		Check	YES	NO
1	Has your doctor ever said that you have <u>and</u> that you should only do physical activity recommended by a doctor?		<input type="checkbox"/>	<input type="checkbox"/>
2	Do you feel pain in your chest at rest when you do physical activity?		<input type="checkbox"/>	<input type="checkbox"/>
3	In the past month, have you had chest pain when you are not doing physical activity?		<input type="checkbox"/>	<input type="checkbox"/>
4	Do you lose you balance because of dizziness or do you ever lose consciousness?		<input type="checkbox"/>	<input type="checkbox"/>
5	Do you have a bone or joint problem (for example, back, knee, hip, neck or shoulder) that could be made worse by a change in your physical activity?		<input type="checkbox"/>	<input type="checkbox"/>
6	Is your doctor currently prescrebing drugs (for example, water pills) for your blood pressure of heart condition?		<input type="checkbox"/>	<input type="checkbox"/>
7	Do you know of <u>any other reason</u> why you should not do physical activity?		<input type="checkbox"/>	<input type="checkbox"/>

**YES to one or more questions**

IF	Talk to your doctor or in person BEFORE you start becoming much more physcially active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.
You	* You may be able to do any activity you want - as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk to your doctor about the kinds of activities you wish to participate in and follow his/her advice
ANSWERED:	* Find out which community programs are safe and helpful for you.

**NO to all of questions**

If you answered NO honestly to all PAR-Q questions, you can reasonably sure that you can:

- \* Start becoming much more physcially active - begin slowly and build up gradually. This is the safest and easiest way to go.
- \* Take part in a fitness appraisal - this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

**Delay becoming much more active:**

- \* If you are not feeling well because of a temporary illness such as a cold or a fever - wait until you better; or
- \* If you are or may be pregnant - talk to your doctor before start becoming more active

Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

**History & Risk Stratification Screening Questionnaire**

**You have had:**

- |  |   |
|--|---|
| <input type="checkbox"/> a heart attack                | <input type="checkbox"/> heart transplantation    |
| <input type="checkbox"/> any heart surgery             | <input type="checkbox"/> congenital heart disease |
| <input type="checkbox"/> coronary angioplasty (PTCA)   | <input type="checkbox"/> heart failure            |
| <input type="checkbox"/> pacemaker/ implantable device | <input type="checkbox"/> cardiac arrhythmia       |
| <input type="checkbox"/> heart valve disease           | <input type="checkbox"/> heart palpitations       |
| <input type="checkbox"/> cardiac catheterization       | <input type="checkbox"/> known heart murmur       |

**You have these symptoms**

- experienced chest pain with mild exertion
- experienced dizziness, fainting, or blackouts with mild exertion
- experienced unusual or shortness of breath during usual activities
- been prescribed heart medications (please indicate):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other Health Issues:**

- you have diabetes
- you have asthma or other lung disease
- you have burning or cramping sensation in your lower legs when walking short distances
- you have musculoskeletal problems that limit your physical activity
- You have concerns about the safety of exercise
- you take prescription medications
- You are pregnant

If you marked any of these statements in the above section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a medically qualified staff.

**Cardiovascular Risk Factors**

- You are a man other than 45 years
- You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal
- You smoke, or quit smoking within the previous 6 months
- Your blood pressure is >140/90 mm Hg
- You do not know your blood pressure
- You take blood pressure medication
- you have been diagnosed with high cholesterol >200 (or HDL is less than 35mg/dl or LDL is
- You do not know your cholesterol level
- you have a close blood relative who had a heart attack before age 55 (father/brother) or
- age 65 (mother/sister)

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\_\_\_\_\_ you are physically inactive (i.e., you get <30 minutes of physical activity on at least 3 days per week)  
\_\_\_\_\_ You are > 20 pounds overweight  
\_\_\_\_\_ Other (specify) \_\_\_\_\_

If you marked two or more of the statements in this section, you should consult your physician or other appropriate health care provider before engaging in exercise. You might benefit from using a facility with a professionally qualified exercise staff to guide your exercise program.

\_\_\_\_\_ None of the above

You should be able to exercise safely without consulting your physician or other appropriate health care provider in a self guided program or almost any facility that meets your exercise program needs

**Which services interest you most?**

\_\_\_\_\_ Personal Movement Training  
\_\_\_\_\_ Movement Correction  
\_\_\_\_\_ Weight Loss  
\_\_\_\_\_ Sports Improvement  
\_\_\_\_\_ Accountability  
\_\_\_\_\_ Coaching  
\_\_\_\_\_ Post / Pre Rehab

**Goals:**

What are your Goals?

What are you doing now toward your goal?

Where would you like to be by when?

Check any pain symptom areas:

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<input type="checkbox"/> None	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Knee
<input type="checkbox"/> Neck	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Foot
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Hips Front	
<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip back	Other: _____
<input type="checkbox"/> Hands		

Activity Level:\*

<input type="checkbox"/> Beginner	<input type="checkbox"/> Advanced
<input type="checkbox"/> Moderate	<input type="checkbox"/> Physically Inactive - Sedentary

Which type of functional movement do you find yourself doing?

**Squat & Reach:**

<input type="checkbox"/> Childcare	<input type="checkbox"/> Horseback Riding	
<input type="checkbox"/> Eldercare	<input type="checkbox"/> Gardening	Other: _____

**Rotational:**

<input type="checkbox"/> Golf	<input type="checkbox"/> Baseball / Softball	
<input type="checkbox"/> Tennis	<input type="checkbox"/> Hockey	
<input type="checkbox"/> Cheer	<input type="checkbox"/> Lacross	Other: _____
<input type="checkbox"/> Soccer		

**Locomotion:**

<input type="checkbox"/> Walk	<input type="checkbox"/> Swim
<input type="checkbox"/> Hike	<input type="checkbox"/> Ski / Snowboard
<input type="checkbox"/> Run / Jog	<input type="checkbox"/> Bike
	Other: _____

**Seated:**

<input type="checkbox"/> Read	<input type="checkbox"/> Sew / Quilt
<input type="checkbox"/> Video Gaming	Other: _____
<input type="checkbox"/> Write	

Which type of fitness programs you enjoy or have interest?

<input type="checkbox"/> Yoga / Pilates / Flexibility	<input type="checkbox"/> Boot Camp / Spin
<input type="checkbox"/> Senior Fitness / Gentle	<input type="checkbox"/> Body Weight / TRX
<input type="checkbox"/> Aerobic: Step / Zumba etc.	<input type="checkbox"/> Boxing / Kickboxing / Marshall Arts
<input type="checkbox"/> Weight Lifting / Strength	<input type="checkbox"/> Endurance Extreme

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Describe your current exercise habits:

Describe your current dietary habits:

**FOR WOMEN ONLY:**

What is your current age? \_\_\_\_\_

Are you currently:

\_\_\_\_\_ Pregnant  
\_\_\_\_\_ Menopause  
\_\_\_\_\_ Peri-Menopausal

\_\_\_\_\_ Regularly menstruate  
\_\_\_\_\_ Not yet menstruatng  
Other: \_\_\_\_\_

Do you have any children? If so, what type of delivery did you have?

Any Diastasis Recti? If so, how severe?

Do you suffer from any low back pain issues? If so, how?

Do you suffer from any abdominal pain? If so, how?

So you suffer from any incontinence? If so, how?

Anything else you would like to share?