

Fit 4 All Abilities Initial Assessment

PERSONAL INFORMATION

Last Name:		First Name:	
Diagnosis:	DOB:	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Street Address:			
City:	State:	ZIP Code:	
Email:			
Home Phone:		Cell Phone:	
Parent/Guardian Name:		Parent/Guardian Cell Phone	
Emergency Contact:		Emergency Contact Phone:	
Relationship:			
Referred By:			

MEDICAL INFORMATION

Is your child currently seeing a PT/OT, ABA therapist, or speech therapist? Yes No
Please list all therapists' names and contact information.

We will not contact them without your consent.

Please list any medical conditions or surgeries:

Date	Medical Condition/Surgery

Please check if you have any of the following:

Heart Disease
Diabetes
Renal disease
Stroke
Asthma

High cholesterol
Obesity
Thyroid problems
GI issues
Seizures

Osteoporosis
Hypertension
Back pain/injury
Anemia

Cardiac Profile:

Has your doctor every said you have a heart condition? Yes No

Do you feel pain in your chest when you do physical activity? Yes No

In the past month, have you had chest pain when NOT doing physical activity? Yes No

Physical limitations

Do you have any physical problems (back, knee, hip, etc) that may inhibit your ability to work out or that could be made worse through physical activity? Yes No

If yes, explain:

Do you have any allergies: Yes No

Please list:

Please list all medications and supplements you are taking:

Medication	Dose	Frequency

WEIGHT HISTORY/FITNESS LEVEL

Ht: _____ Wt: _____

Have you trained in a gym before? Yes No Have you worked with a trainer before? Yes No

Current Fitness Level - 1 to 10 (10 very active)

Do you exercise: Yes No

If yes, describe your exercise routine:
How many days per week?
How many minutes per session?

What are your current health and fitness goals? Check all that apply

- Build Muscle
- Body-Fat Loss
- Create Consistency
- Decrease Stress Levels
- Fun Workout
- Improve Cardio Fitness
- Improve Flexibility
- Improve Mood/Feel Better
- Improve Performance
- Increase Energy Levels

Others?: _____

How often would you like to see a trainer to help you achieve your goals?

What days of the week are best for you to commit to an exercise program?

What is the best time of day for you to exercise?

BEHAVIORS

Are there any behavior issues we should be aware of?

Are there any sensory issues we should know about?

How many hours of sleep do you get? What time do you go to bed?

What fluids do you drink a day and how much?

What activities are you presently involved in?

What is an appropriate reward for your child?

What motivates your child?

What songs and games does your child like?

Please list any other information you would like us to know:

PLAN/NOTES


