

**The Phoenix Personal Training**

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**www.thephoenixpersonaltrainer.com**

**Assessment/PAR-Q** Todays Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

 Male Female Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ text okay no texts, please

Emergency Contact Name and Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **YES NO** |

**Medical History (check yes or no)**

1. Has your doctor ever said that you have a heart condition

and that you should only perform physical activity recommended by a doctor?

1. Do you feel pain in your chest when you perform physical activity?
2. Do you have a pacemaker or implantable defibrillator?
3. In the past month, have you had any chest pain when not performing physical activity?
4. Do you have a history of diabetes or other metabolic disease? (thyroid, renal, liver)
5. Do you lose your balance because of dizziness or do you ever lose consciousness?
6. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
7. Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?
8. Are you currently or have you been a cigarette smoker in the past?
9. Are you pregnant?

Orthopedic History: Indicate any problem areas

Foot/Ankle \_\_\_\_\_\_\_\_\_\_\_ Shoulder \_\_\_\_\_\_\_\_\_\_ Hernia \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Knee \_\_\_\_\_\_\_\_\_\_\_ Elbow \_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hip \_\_\_\_\_\_\_\_\_\_\_ Hand/Wrist \_\_\_\_\_\_\_\_\_\_\_ Back \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neck \_\_\_\_\_\_\_\_\_\_\_\_

Other pertinent medical information including past surgeries, and any activity limitations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational/General:**

1. What is your current occupation?
2. Does your occupation require extended periods of sitting?

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1. Does your occupation require repetitive movements?
2. Please rate your daily stress as: LOW, MODERATE, or HIGH
3. How frequently do you exercise?
4. How much sleep do you get per night on average?