WALDO COUNTY YMCA
ADULT Personal Fitness Profile

Date: _____ Appointment Date: _____

Name: _____ Preferred appointment time: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home Phone: _____

Date of Birth: __/____/____ Age: _____ Gender: M / F / U Height: _____ Weight: _____

Occupation: _____ Work Phone: _____

Primary Physician: _____ Physician Phone: _____

IN CASE OF EMERGENCY CONTACT: Name: _____

Phone: _____ Relationship: _____

Waldo County YMCA recommends that all individuals consult their physician prior to beginning a new exercise program.

None of the following questions are for diagnostic or treatment purposes. Mark all true statements.

HISTORY – You have had:

□ a heart attack
□ heart surgery
□ cardiac catheterization
□ coronary angioplasty (PTCA)
□ pacemaker / implantable cardiac
□ angina pectoris
□ defibrillator / rhythm disturbance
□ heart valve disease
□ heart failure
□ heart transplantation
□ congenital heart disease
□ stroke
□ embolism or aneurysm

If you have marked any of the statements in this section, we will need to have medical clearance prior to our scheduling a fitness orientation. The Physician Clearance Form is available at the front desk. This form requires your signature and your physician's name, address, and phone number. When we receive this information, we will fax the form to your healthcare provider. In most cases they are returned within 24 hours.

We aim to make your exercise experience to be as safe as possible. The information your physician provides can be invaluable when creating a safe exercise program.

SYMPTONS:

□ You experience chest discomfort with exertion
□ You experience unreasonable breathlessness
□ You experience dizziness, fainting, and/or blackouts
□ You take heart medications.

OTHER HEALTH ISSUES:

□ You have musculoskeletal problems. Problems with:

□ Shoulder(s) □ Neck □ Back □ Hip(s) □ Knee(s) □ Ankle(s) □ Other _____

Please describe: _____

□ You are pregnant. If yes, check w/ your physician before beginning an exercise program. Due date: _____

□ Asthma
□ Chronic bronchitis
□ Thyroid problems
□ Peripheral vascular disease
□ Emphysema
□ Claudication
□ Phlebitis

157 Lincolnville Avenue, Belfast, Maine 04915
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Updated3.13.22
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CARDIOVASCULAR RISK FACTORS:

□ You are a man older than 45 years.
□ You are a woman older than 55 years or you have had a hysterectomy or you are postmenopausal.
□ You smoke or have smoked in the past 6 months. □ Your blood pressure is greater than 140/90 mm Hg.
□ You don't know your blood pressure. □ You take blood pressure medication.
□ Your blood cholesterol level in greater than 240mg/dl.
□ You don't know your cholesterol level.
□ You have a blood relative who has had a heart attack **BEFORE** age 55 (father/brother) or 65 (mother/sister).
□ You are diabetic or take medicine to control your blood sugar.
□ You are physically inactive *(i.e., you get less than 30 minutes of physical activity on at least 3 days/week.)*
□ You are more than 20 pounds' overweight.

If you have marked two or more of the statements in this section, you should consult your physician before beginning a new exercise program.

1) Are you presently taking medication? ☐ Yes ☐ No

If yes, give name and dosage. Please attach an additional sheet if necessary.

2) Have you had any recent surgery? ☐ Yes ☐ No

If yes, describe: _____

3) What is your present level of physical activity? _____

☐ Sedentary ☐ Active lifestyle ☐ Currently exercising ☐ Athlete

4) If you currently exercise, what exercise activities does your workout include? _____

_____

5) What are your short and long term goals for exercise, health, and fitness?

☐ Weight loss ☐ Health/wellness ☐ General strength ☐ Bodybuilding ☐ Sculpting

☐ Cardiovascular endurance ☐ Flexibility ☐ Sport specific ☐ Stress reduction ☐ Other

Short term: _____

Long term: _____

6) Are you presently on a special diet? ☐ Yes ☐ No If yes, please describe: _____

_____

7) Do you have any physical condition that might affect your ability to undertake an exercise program?

☐ Yes ☐ No If yes, please explain: _____

_____

Signature: _____ Date: _____

Parent/Guardian's signature required if under 18 years of age: _____

TO BE COMPLETED BY TRAINER: Blood Pressure: _____ Resting Heart Rate: _____

Percentages THRZ: _____ Beats/ 10 sec.: _____

Trainer: _____ Date: _____

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