**PHYSICAL FITNESS ASSESSMENT IN PHYSIOTHERAPY DEPARTMENT FMCA**

NAME OF CLIENT…………………………………………………………………………………………………………………………………

Age:…………… D.O.B: ……………………………………………Date of Assessment-………………………………………………

Present Complaint: ……………………………………………………………………………………………………………………………..

History Source: ……………………………………………………………………………

History:……………………………………………………………………………………………………………………………………………………..………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

MEDICAL HISTORY

a. Are you on treatment for any of the following? (Tick as many as applicable)

High blood pressure Diabetes Asthma Heart disease Sickle cell disease Others

b. Major illness/injuries during the last 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Drug History: ……………………………………………………………………………………………………………………………………..

Past Surgical History:………………………………………………………………………………………………………………………….

Family/Social History:………………………………………………………………………………………………………………………….

HISTORY OF FITNESS PROGRAM

Previous participant in fitness program(s) Yes No. Duration of program: \_\_\_\_\_\_\_\_ weeks

Reason(s) for stopping: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Major reason(s) for wanting to participate in this fitness program:

I want to shed some weight

I want to be more fit

I want to improve my shape

I want to regain my previous shape after child birth

Others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent:**

I hereby indicate my willingness to participate in the test and exercise program and to comply with all instructions I may be given.

……………………………………………………. Date ………………………….

Signature

**EXAMINATION**

ANTHROPOMETTRIC MEASUREMENT

Height (m):……………………………………

Weight(Kg) :……………………………………

Waist Circumference(cm) :……………………………………

Hip Circumference (cm) :……………………………………

Waist to Hip Ratio:……………………………………

BMI(Kg/m2) :……………………………………

VITALS :……………………………………

-BP (mmHg) :……………………………………

-PR(bpm) :……………………………………

Maximum Heart Rate(220-age) :……………………………………

*NB: Target Heart Rate for Moderate Intensity= 60-65% of Max HR*

OUTFITS FOR FITNESS AND PRECAUTION

* Exercise clothing and shoes - Boot (1”allowance) - Top / Short.

PRECAUTION BEFORE EXERCISE

- Wear appropriate outfit - No food for 2 hours - No caffeinated beverages.

- No alcohol for 24 hours before assessment / testing - No smoking for 2 hours before testing.

PLAN OF TREATMENT:…………………………………………………………………………………………………………………………

MEANS OF TREATMENT:………………………………………………………………………..……………………………………………

………………………………………………………………………..………………………………………………………………………………….

FITNESS ASSESSMENT QUESTIONNAIRES AND WAIVER

Please answer all questions accurately and honestly to allow us to fully determine your individual needs.

Date -------------------------

First Name -------------------------------------------------- Last Name----------------------------------------------------

Address ------------------------------------------------------------ City -------------------------- State --------- Zip -------

Home Phone --------------------------------------------- Business or Alternate Phone --------------------------------

Age ---------------------------------- Height ----------------------------- Weight --------------------------------------

|  |
| --- |
| For questions 1-9. Have you experienced:  1.Pain or discomfort (or angina equivalent) in the chest, neck, jaw, arms, or other areas  That may be due to ischemia (decreased blood flow) YES NO UNSURE |

2. Shortness of breath at rest or w/mild exertion YES NO UNSURE

3. Dizziness or syncope at rest or w/mild exertion YES NO UNSURE

4. Orthopnea/paroxysmal nocturnal dyspnea (short of breath ) at rest or w/mild exertion. YES NO UNSURE

5, Edema (excessive accumulation of issue fluid) YES NO UNSURE

6, Palpitations or tachycardia (sudden rapid heartbeat) YES NO UNSURE

7. Intermittent claudication (lameness due to diseased blood flow) YES NO UNSURE

8. Known heart murmur (abnormal heart sound) YES NO UNSURE

9. Unusual fatigue or shortness of breath with usual activities YES NO UNSURE

10. Do you smoke? YES NO

11. Do you drink occasionally? YES NO

12. Have you been a member of a health club before? YES NO

13. Have you been exercising regularly for the past 6 months? YES NO

14. Pleas rate your exercise level on a scale of 1 to 5 (5 indicating very strenuous) for each age range through your present age,

15-20 -------- 21-30 ------------- 31-41------------ 41-50 -------------- 51+ -----------------------

15. Are you currently involved in regular endurance (cardiovascular) exercise?

Yes No If yes, please specify the type of exercise(s)--------------------------- ------------minutes/ day --------days/week

16. How often do you eat out? ------------------------- times per week.

17. Iwould like to

Loose weight Gain weight Feel better Look better Live healthier

**PHYSIOTHERAPY AND FITNESS CLINIC - PHYSICAL FITNESS ASSESSMENT FORM**

Name ---------------------------------------------------------------------------- Clinic No ---------------------------------

Age ------------ ------------years Sex: M F Occupation: ------------------------------------------------

Address: --------------------------------------------------------------------- ---------------Phone: -------------------------

Daily activities please assign numbers 1 to 7 to the following activities to indicate the relative amount of time you spend on each of them. Assign 7 to the activity/activities you are most involved in, and 1 to the one (s) you are least involved in during the walking hours of an average day:

lying (not sleeping)

sitting (reading, writing, watching TV/Video, at meetings etc.)

driving (within town, on high way)

standing (kitchen work, teaching etc.)

walking

bending (sweeping, lacing/buckling shoes, bathing small children, changing baby’s diaper etc.)

kneeling (praying)

How do you share your 24 hour day between walking and sleeping?

Walking -------------------- hours sleeping --------------------hours

Leisure-time activities/sporting activities during last 12 months activities: ----------------------------------

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Drinking Habits

Alcohol: Hot drink Beer Palm wine Wine None

Amount per week ----------------------- short/glass/bottles

Non-alcoholic (other than water or soda water): Soft drinks Fruit juice Fruit drink None

Amount per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ glass/bottle

Smoking : Cigarette Cigar None. No of packs/sticks per week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stimulants: Coffee Tea Kolanut Bitter kola None. No of cups/nuts per week \_\_\_\_

Eating: No of major meals per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of snacks in between meals per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Types of snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_