



Personal Inventory Form

Please answer the following questions as completely as possible. All information is voluntary and personal information will be kept strictly confidential.

Name: _____ Date of Birth: _____ Age: _____

Medical Background

Are you currently under the care of a physician? Yes No If yes, please explain:

Please list any medications you are currently taking:

Name of Medication

Purpose for taking

Have you had a complete physical in the past year? Yes No

Smoking history (please select one choice):

- Currently Smoke
- Quit less than one year ago
- Quit over one year ago
- Never smoked

Please check all of the following that apply to you. Please explain in the space provided or attach a separate sheet.

- Have you or anyone in your family had coronary artery disease?
- Have you ever fainted or felt dizzy after exercise?
- Has a doctor ever said that your blood pressure is too high?
- Do you have heart trouble, a heart murmur or have you had a heart attack?
- Do you have diabetes, thyroid condition or any other chronic condition?
- Are you now or have you been pregnant during the last three months?

Please explain any answers you marked with a yes:

Do you have any conditions that you or your doctor says may limit your physical activity? Yes No

If yes, please explain:

Please list (**including dates**) any current and past injuries/conditions that have limited your physical activity.

Injury/condition: _____ Date: _____

Injury/condition: _____ Date: _____

Fitness Background

Please circle one:

I have been Running Run/Walk Walking

For how many Months _____ and/or Years _____ consistently.

What is the approximate length (in miles or minutes) of the **longest** runs/walks for each of the last six weeks? Miles Minutes (please check one)

Week 1: Week 2: Week 3: Week 4: Week 5: Week 6:

How many days per weeks do you *run, run/walk or walk* (circle mode)? _____

Please list any other activities you **currently** engage in (i.e. strength training, aerobics, other sports, etc.):

Activity: _____ Minutes/day: Frequency (# of times/week):

Activity: _____ Minutes/day: Frequency (# of times/week):

What is your **Primary** training goal for this training program? (You may rank multiple goals: 1=Primary)

- | | |
|--|--|
| <input type="checkbox"/> Finish the race | <input type="checkbox"/> Weight Loss / Fat Reduction |
| <input type="checkbox"/> Improve my race time | <input type="checkbox"/> Have fun |
| <input type="checkbox"/> Improve level of fitness | <input type="checkbox"/> Meet people |
| <input type="checkbox"/> Maintain current level of fitness | <input type="checkbox"/> To learn about Living a Healthy Lifestyle |

Other: _____

Distance Training Group Questions ONLY

What is the approximate length of your longest runs over the last six weeks? _____

How many days per week do you usually run? _____

What is your typical long run training pace: _____ min/mile (i.e. 10 min/mile).

Have you done any track workouts in the past? Yes No

How many of the following distances have you completed and what is your personal best time and date for each?

	# Completed	Most Recent Time	Date of Most Recent Time	Best time	Date of Best Time
5K					
10K					
½ Marathon					
Marathon					

Please let us know of any other information you feel would be important for us to know regarding your fitness or health background.

Thank you!!!!