Think Outside The Diamond. LLC
Fitness Evaluation

Personal Information

Please enter some basic information about yourself below. All of the information is required to participate in this training.

Name: _____ Birthdate: _____

Address: _____
Street City State Zip

Phone: (_____)_____ Other Phone: (_____)_____

Email Address: _____

Gender? ○ Male ○ Female

Age? _____

Weight? _____ lbs. / 60 Yard Dash Time?_____

Height? _____ ft. _____ inches

What sport(s) are you training for? _____

What position(s) do you play? _____

Liability Waiver

I hereby release Rick Saggese and Think Outside The Diamond, LLC from any and all liability in connection with ALL services and products offered by Think Outside The Diamond, LLC.

_____
Signature (Parent or Guardian if under age of 18)

_____
Name Printed

Medical History

Check the appropriate box for each question.

Yes	No	
☐	☐	Do you have a physician diagnosed heart condition? (Specify: _____)
☐	☐	Do you feel pain in your chest when you do physical activity?
☐	☐	In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	Do you have a bone or joint problem that could be made worse by a change in your physical activity?
☐	☐	Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? (Specify: _____)
☐	☐	Do you know of any other reason why you should not do physical activity?
☐	☐	Are you male over age 44 or a female over age 54?
☐	☐	Do you have high blood pressure?
☐	☐	Is your total cholesterol over 200, or your HDL less than 30?
☐	☐	Do you smoke?
☐	☐	Is your weekly activity level less than one hour per week?
☐	☐	Do you have a family history of cardiorespiratory or metabolic disease?

Please check any of the conditions which apply to you.

General Information

- ☐ Heart Disease or Stroke
- ☐ High Blood Pressure
- ☐ High Triglycerides
- ☐ Cancer
- ☐ Lung/Pulmonary Disease
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Ulcer
- ☐ Gastrointestinal Disease
- ☐ Depression
- ☐ Prostate Disease
- ☐ Diabetes Mellitus
- ☐ Obesity
- ☐ Arthritis
- ☐ Anemia
- ☐ Food Allergies Confirmed By Physician
- ☐ Neuromuscular Disease
- ☐ Arteriosclerosis
- ☐ Gall Bladder Disease
- ☐ Low Back Pain Within Last 6 Months
- ☐ Psychological Problems
- ☐ Anorexia
- ☐ Bulimia
- ☐ Compulsive Overeating Disorder
- ☐ Other Medical Problems
- ☐ Monitored Or Have Been Advised To Be Monitored By A Physician
- ☐ Recommended High Level Care
- ☐ Special Diet

1. Do you currently exercise at least three times a week? ○ Yes ○ No

2. Estimated Body Fat? (Circle One) ○ < 10% ○ 10 – 20% ○ 20%

3. Have you done any resistance/speed training in the past? ○ Yes ○ No

   If yes:

   (a)How long have you trained?
   - ○ Less than 6 months
   - ○ 6 months to 1 year
   - ○ More than 1 year

4. Number your fitness goals from 1 – 8 in level of importance

   (1 = most important / 8 = least important)
   - ☐ Decrease Body Fat
   - ☐ Increase Muscular Strength

- [ ] Improve Sport Performance
- [ ] Increase Flexibility
- [ ] Increase Muscle Mass
- [ ] Lose Weight
- [ ] Improve Cardiorespiratory Fitness Level
- [ ] Other: _____

5. Do you have any time restraints? ○ Yes ○ No