



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!!!!