

Certified Obesity Management Specialist

Exercise Consult

American College of Wellness

Name: _____ Date: _____

S: **Current Aerobic Activity:** _____ minutes _____ days/week _____ NONE

_____ walk/jog _____ bike _____ glider, gazelle _____ elliptical trainer
_____ water aerobics _____ swimming _____ aerobic tapes/dance _____ other _____

Weight Training _____ set(s) _____ repetitions _____ days/week _____ NONE

Exercise History Home Equipment/Gym: _____

Exercise Interests: _____

Other: _____

O: **Medical History** _____ year old _____ RHR _____ bpm

BP _____ Height _____ Weight _____ lbs SPO2% _____

Medication _____

Physical Limitations _____

Other: _____

Risk Factors

_____ none _____ Hypertension _____ Hyperlipidemia _____ Diabetes
_____ Smoking _____ Inactivity _____ Family History

Forms

_____ medical history _____ waiver of liability _____ PAR-Q

A: **Body Composition** BMI _____ frame size _____ method _____

% fat _____ fat weight (lbs) _____ lean weight (lbs) _____

recommended % fat _____ recommended weight (lbs) _____

Waist _____ inches Hip _____ inches Waist/Hip _____

P: _____

Signature _____ Date: _____ Time: _____