



## Golf Fitness Profile

### General Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender M F  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Email address \_\_\_\_\_ Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
How did you hear about us? The Peak \_\_\_\_\_, Golf Pro (name) \_\_\_\_\_,  
Friend (name), \_\_\_\_\_ Other \_\_\_\_\_.

### Golf Information

You are a right/left handed golfer. What is your handicap? \_\_\_\_\_  
How many times per week do you play golf on average? \_\_\_\_\_  
Who is your local golf pro? \_\_\_\_\_  
What are you working on with your swing? \_\_\_\_\_  
\_\_\_\_\_  
Name two things you'd like to see change in your game or swing? \_\_\_\_\_  
\_\_\_\_\_  
Main goals: treat an injury \_\_\_\_\_, prevent an injury \_\_\_\_\_, improve golf  
performance \_\_\_\_\_, develop a golf fitness routine \_\_\_\_\_, other \_\_\_\_\_

### Fitness Information

How long have you been working out? \_\_\_\_\_  
Describe your usual work outs (frequency, time, equipment, exercises, etc.) \_\_\_\_\_  
\_\_\_\_\_  
What exercise equipment do you have available to you? \_\_\_\_\_  
\_\_\_\_\_  
What days do you prefer to work out? \_\_\_\_\_  
\_\_\_\_ Mon, \_\_\_\_ Tues, \_\_\_\_ Wed, \_\_\_\_ Thurs, \_\_\_\_ Fri, \_\_\_\_ Sat, \_\_\_\_ Sun

### Medical Information

Are you here for a specific injury or medical diagnosis? Y N \_\_\_\_\_  
Please check if you have any problems with your: \_\_\_\_ low back, \_\_\_\_ neck,  
\_\_\_\_ shoulder, \_\_\_\_ elbow, \_\_\_\_ wrist, \_\_\_\_ hip, \_\_\_\_ knee, \_\_\_\_ ankle  
Please elaborate on other pertinent past injuries. \_\_\_\_\_  
\_\_\_\_\_

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Do you have a doctor's permission to exercises? Y N

Do you have a family history of heart disease? Y N

Has your doctor ever told you that you have a heart condition? Y N

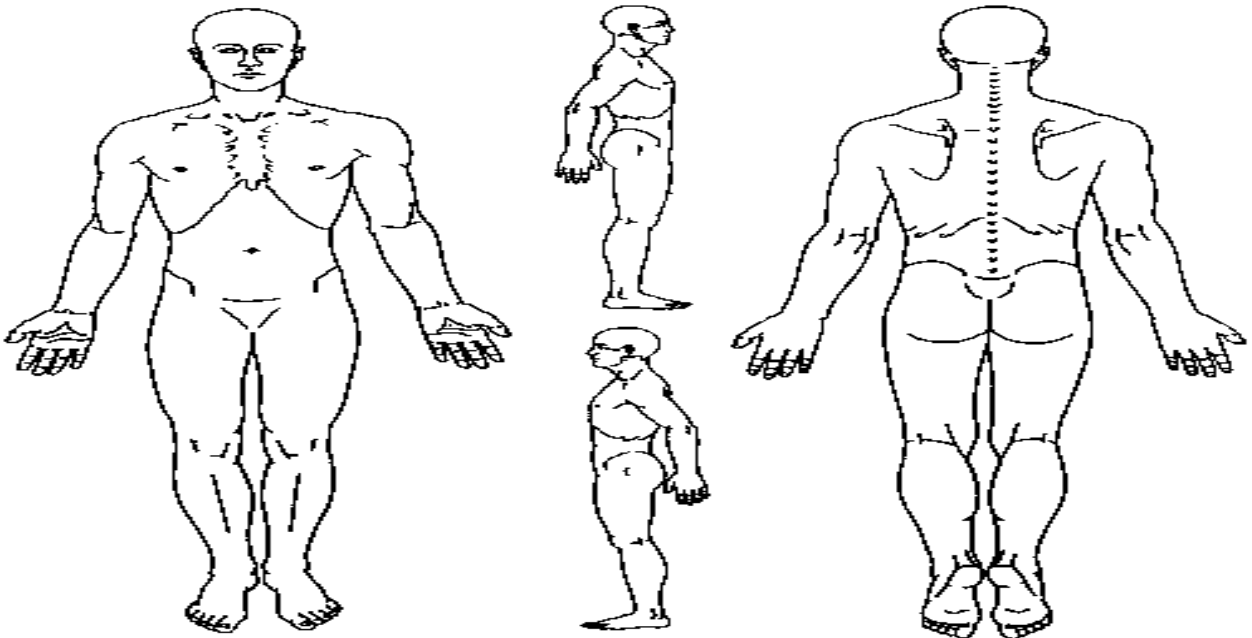
If so, please describe the condition. \_\_\_\_\_

Have you had chest pain while exercising or engaging in physical activity? Y N

Have you had dizziness or loss of consciousness while exercising or engaging in physical activity? Y N

**Please mark any relevant symptoms you have below.**

(A: Ache S: Stabbing R: Radiating P: Pins and Needles O: Other)



I understand that there is risk involved in all physical activity. I affirm that I have my doctor's permission to exercise. I understand that all fitness activities should be approved by my doctor. I understand that I assume all risk involved in engaging in physical activity and that I must monitor my own condition at all times.

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**Signature**

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**Date**