



## VO2 Test INTAKE FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

How many days per week do you exercise? \_\_\_\_\_

What types of exercise? \_\_\_\_\_

Please list any health concerns, injuries or known risks? \_\_\_\_\_

What are your fitness goals? \_\_\_\_\_

\_\_\_\_\_

Signature of Participant