978-768-0111

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PERSONAL INFORMATION

Name ____________________________________ Date ____________________________________

Consultation Date _________________________ Trainer _________________

Email________________________________

Home Phone _____________________________ Work Phone ______________________________

Address ____

City _____________________________________ Postal Code ______________________________

Occupation _______________________________ Employer ________________________________

Date of Birth______________________________ Gender ___ Age ___ Marital Status _________

Physician __________________________________ Physician's Phone _________________________

Physician's Address ____

A: Personal Fitness Profile / History

1. Are you currently exercising? o YES o NO

If yes, what type of exercise? ____

Frequency: _______________________________ Duration: ________________________________

How many times per week are you able to exercise? o 4 o 3 o 2 o 1

Do you stretch before and/or after exercise? ____

What recreational activities do you participate in? _____________________________________

Have you been on a regular fitness routine in the past? o YES o NO

Duration: ____

Have you ever utilized the services of a personal trainer?

o YES o NO

If yes, how long? __________________________ If no, why not?___________________________

11. Are you confident in your training knowledge and abilities?

o YES o NO

Explain: ____

Medical History

Past or Present, do any of the following conditions relate to you?

- Heart Disease
  - High blood pressure
  - Low blood pressure
  - Angina Pectoris
  - Myocardial Infarction
  - Heart murmur
  - Cardiac Arrhythmia
  - Tachycardia
  - Rheumatic Fever
- Cardiovascular Disease
  - Stroke
  - Arteriosclerosis
  - Aneurysm
  - Varicose Veins
- Respiratory Disease
  - Asthma
  - Emphysema
- Muscular-Skeletal Disorder
  - Osteoporosis
  - Rheumatoid Arthritis
  - Osteoarthritis
  - Tendonitis/Bursitis
  - Whiplash
  - Fibromyalgia
  - Herniated Disc
- Neurological Disorder
  - Sciatica
  - Epilepsy
  - Insomnia
  - Impingement Syndrome
- Metabolic Diseases/Disorders
  - Diabetes
  - Hyperthyroidism
  - Hypothyroidism
  - Renal Disease
- Miscellaneous
  - Hernia
  - Anemia
  - Ulcers
  - Allergies
  - Chronic Fatigue Syndrome
  - Tumor/Cyst
  - Auto Immune Disorder
  - Other
- If one or more of the above conditions relate to you, please provide a brief detail

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1. Have you ever been treated by:
    - Chiropractor
    - Physiotherapist
    - Other

When? _________________________________ Why? _____________________________________

2. Are you accustomed to vigorous exercise?
    - YES
    - NO

3. Do you experience the following symptoms prior to, during, or after physical activity?

- Muscle Cramps
- Dizziness
- Neck or back pain
- Swelling of joints
- Coughing / nausea
- Chest Pain

3. Can the above pain or discomfort be described as a:

- Dull Ache
- Sharp Stab
- Numbness or Tingling

Other: ____

4. Is there any other physical reason (not mentioned) why you should not follow an

exercise program? ____

Do you experience pain in the following areas? If yes please explain\

- Toes
- Forefoot
- Arch
- Heel
- Ankle Leg
- Upper/Lower Leg
- Knee
- Hip
- Upper/Lower Back
- Fingers
- Hand
- Wrist
- Elbow
- Upper Arm

Medications

1. Cardiovascular agents (such as beta blockers, nitrates, calcium, channel antagonists,

Anti-arrhythmic agents, ACE inhibitors, alpha receptor blockers) ___________________________

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2. Anticoagulants and anti-platelet agents ____

- Shortness of breath o Headaches/Migraines o Grinding Joints
- Irregular bowel movement

3. Digitalis glycosides ____

4. Decongestants and antihistamines ____

5. Diabetic agents (insulin/hypoglycemic agents)____

6. Electrolytes____

7. Hormones (including birth control pill) ____

8. Lipid lowering agents ____

9. Psychotropic agents (i.e. anti-anxiety, anti-depressants, antipsychotic agents, etc.) __________

10. Respiratory therapy agents (bronchial dilators)____

11. Sympathomimetic agents ____

12. Diuretics____

13. Corticosteroids ____

14. Vasodilators ____

15. Non-steroidal anti-inflammatories____

16. Muscle relaxants ____

17. Analgesics____

18. Narcotics (i.e. codeine) ____

Other (include medications that you do not know category for) _____________________________

Goals & Results

What areas do you wish to transform?

- Weight Loss/Gain
- Aerobic Capacity
- Muscle
- Toning/Strength/Endurance
- Body Building
- Intensity Training
- Flexibility
- Sport Specific Conditioning o Stress Management
- Knowledge/Education
- Nutritional Wellness Counseling

Other ______

In your own words, please tell us what you hope to achieve.

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