**Fitness Consultation Form**

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

|  |  |  |
| --- | --- | --- |
| Cell Number:  | Other Number: | Email: |
| Age: Gender: | Height: | Weight: |
| Emergency Contact: Name: Number: |

**Goals:**What would you like to achieve? (i.e.: General overall fitness/ Lifestyle change/ Improve body composition/ Bodybuilding/ Sport Conditioning/ Post-rehabilitation, etc.) – The more detailed the information, the better we can serve you!

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**More Specific:** Think of up to 3 specific goals that you would like to achieve and the time frame for each.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle**:
What is your current fitness related activity experience? (Beginner/ Returnee/ Active, What have you been doing for the last 6 months?)

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Circle types of exercise that interest you:

|  |  |  |  |
| --- | --- | --- | --- |
| Walking | Basketball | Tennis | Jogging |
| Rowing | Swimming | Cycling | Football |
| Soccer | Group Exercise | Strength Training | Skating |
| Stretching / Yoga | Competitive Sports | Crossfit / Bootcamp | Other: |

Scale of 1 – 10 how important is the following to you?

Extremely Important Somewhat Important Not Important

 1 2 3 4 5 6 7 8 9 10

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Cardiovascular Fitness | \_\_\_Build Muscle | \_\_\_Weight Loss | \_\_\_Improve Mood and Stress |
| \_\_\_”Tone” my body | \_\_\_Improve Flexibility | \_\_\_Increase Strength | \_\_\_Increase Energy Level |
| \_\_\_Feel Better | \_\_\_Enjoy Life | \_\_\_Improve Sport Performance | Other: \_\_\_ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Diagnosed** | **Medications** |  | **List of Medications:** |
| **Heart Attack** |  |  |  |  |
| **Stroke** |  |  |  |  |
| **Diabetes** |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |
| **High Cholesterol** |  |  |  |  |

**History:**Have you ever been diagnosed with the following and been prescribed medications:

Please check any conditions that are present in your family, of which you are aware of:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Father** | **Mother** | **Sister** | **Brother** | **Grandparents** |
| **Heart Attack** |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |
| **High Cholesterol** |  |  |  |  |  |

Please list any previous bone/joint injuries or conditions:

Please list any significant health/medical conditions (i.e. previous surgeries, current pregnancy, diseases, etc.)

**Other:**

Are you currently taking any nutritional supplements? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle the meals you consume in an average day:
Breakfast Snack Lunch Snack Dinner Snack

How many hours do you work/study a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Meeting time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: