Personal Training Consultation Form

Please complete this form prior to your first session. Email completed form to The Rehab at sbolz@therehabtx.com or fax to (281) 288 2550.

Last Name	**First Name**
Address	
Email address	
Mobile	
Home Phone	
Work Phone	
Date of Birth	
Occupation	
Emergency Contact **Name** **Address (if different to above)** **Mobile** **Home Phone** **Work Phone**	

To identify any known disease, or signs or symptoms of disease, or if you may be at a higher risk of an adverse event during physical activity/exercise please answer the following questions:

1. Has your doctor ever told you that you have a heart condition or have you ever suffered a stroke? **YES / NO**
2. Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise? **YES / NO**
3. Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance? **YES / NO**
4. Have you had an asthma attack requiring immediate medical attention at any time over the last 12 months? **YES / NO**
5. If you have diabetes (type 1 or 2) have you had trouble controlling your bloody glucose in the last 3 months? **YES / NO**
6. Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise? **YES / NO**
7. Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity/exercise? **YES / NO**

If you answered **YES** to any of these questions please seek guidance from your regular physician or contact Spring Chiropractic to make an appointment with one of their doctors prior to undertaking physical activity/exercise with our Personal Trainer.

If you have answered **NO** to all of these questions and you have no other concerns about your health please complete remainder of this form.

Please state your:
Height? _____
Weight? _____

Do you? Smoke? **YES/NO** How many/How often? _____
Drink? **YES/NO** How many/How often? _____

How many glasses of water do you drink per day?
□ Less than 4 glasses □ 4-6 glass □ 6-8 glasses □ 8+ glasses

How much sleep do you get per night?
□ Less than 4 hours □ 4-6 hours □ 6-9 hours □ More than 9 hours

Have you been told that you have high blood pressure? **YES / NO**
If yes, please provide details:

Have you been told that you have high blood sugar? **YES / NO**
If yes, please provide details:

Have you spent time in hospital for any medical condition/illness/injury during the last 12 months? **YES / NO**
If yes, please provide details:

Have you been told that you have high cholesterol? **YES / NO**
If yes, please provide details:

Are you currently taking a prescribed medication(s) for any medical condition(s)? Please list.

Are you pregnant or have you given birth within the last 12 months? **YES / NO**

Do you have any muscle, bone or joint pain or soreness that is made worse by particular types of activity? **YES / NO**
If yes, please provide details:

How long has it been since you exercised? When did you last perform regular exercise? Describe your prior exercise regimen.

Are you currently doing any exercise? **YES / NO**

Frequency – How many times per week? _____
Intensity – Was the intensity low, moderate or high? _____
Duration – How long did each session last on average? _____
Describe your exercise regimen?
_____

Do you enjoy exercise? What exercise do you enjoy doing the most?
How many days per week are you prepared to exercise (either with a personal trainer or on your own)?
What are your reasons for engaging a personal trainer? □ Weight Loss □ Improve fitness □ Change the way you look or feel about your body □ Medical or health reasons □ Referred by GP/allied health professional □ Stress □ Other, please state
What would you like to achieve with the help of a personal trainer?
Of the reasons above for engaging a trainer what is the goal you would most like to achieve? Do you have a timeframe in mind?
Why is this important to you?
What barriers can you see that may inhibit you from achieving these goals?
On a scale of 1-10 (1 being least & 10 being most) how important is it that you achieve these goals?
What's your diet like? Do you require advice or assistance with your diet from one of our Registered Dietitians?

Please tick if you are interested in any of The Rehab's other services?

□ Small Group Personal Training
□ Yoga or Pilates
□ Nutrition Counseling
□ Run or Triathlon Coaching
□ Nutrition Seminars
□ Weekend or Evening Group Classes
□ Massage
□ Individualized Corporate Programs

I have answered these questions to the best of my ability and all of the information provided within this form is true and correct to the best of my knowledge.

Please Sign _____ Date / /

□ I do not consent to this information being used exclusively by The Rehab for statistical data collection.
□ I do not wish to be included on The Rehab's email list.