



Fitness Training and Nutritional Consulting, Inc.

Date _____

GENERAL INFORMATION

Last Name: _____ First Name: _____

Height: _____ Approximate Weight: _____ Age : _____ Male Female

Home Phone: () _____ Work or Cell Phone: () _____

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Email: _____

Occupation: _____ What is your stress level (scale of 1, low – 5, high) _____

EMERGENCY CONTACT INFORMATION

His/Her Name: _____ Relation: _____

Home Phone: () _____ Work or Cell Phone: () _____

PHYSICIAN INFORMATION

Name: Dr. _____

Address: _____
Street City State Zip

Phone # : () _____ Fax # : () _____

PERSONAL HEALTH GOALS, INFO & BACKGROUND

My goals are: fat loss general fitness improved flexibility aerobic conditioning muscle strength

Describe any health conditions that you are interested in addressing:

List medications and the condition for which you are taking them:

List supplements you are taking and the dosage (i.e calcium citrate, 400mg twice per day)

Do you have any injuries or physical limitations? Yes No

If Yes, please describe:

How many hours of sleep do you average per night? _____

DIETARY/ACTIVITY INFO

Describe any digestive issues: _____

Vegetarian (eat eggs and dairy) Yes No Vegan (No eggs or dairy) Yes No

Describe any known food allergies: _____

Do you have any dietary restrictions? (or list foods you do not like to eat)

Do you consume: coffee/caffeine _____ regular or diet soda _____ alcohol _____

How much water do you drink per day? _____ Do you smoke? Yes No

Do you take any pain medications (such as Ibuprofen, Advil, Aleve) regularly? Yes No

Cholesterol levels (if known): Total _____ LDL _____ HDL _____ Blood pressure _____

Please describe your family medical/dietary history (i.e. father has diabetes, heart disease, obesity, arthritis, depression etc.)

Please list your physical activities and the frequency: (e.g. run/walk Lake Padden 2x per week, yoga class 1x week, gym workout 3x week)

How much time do you have in your daily/weekly schedule for physical activity? _____

Have you ever worked with a personal trainer before? Yes No

METHOD OF PAYMENT

Paypal Personal Check Cash Package/Membership _____

CANCELLATION POLICY

Cancellations must be made 24- hours or more in advance of a pre-scheduled appointment to avoid being billed for the session.

CONSENT WAIVER, PATIENT RIGHTS, & AUTHORIZATION

I have received a copy of the Informed Consent Waiver/Hold Harmless Agreement and have read the cancellation policy. Also, I give authorization to contact my physician if necessary.

Signature of Participant

Date