



Personal Training Information and History

Name:	Date of Birth:
Address:	
Phone Number:	Email:
Gender:	Age:
Height:	Weight:

Emergency Contact Information

Name: _____

Relationship: _____

Cell Phone: _____ Work Phone: _____

How do you prefer to be contacted? (please circle)

Email Phone Text Other (please specify): _____

How did you hear about Crystal Coast Wellness and Performance Center? (please circle)

Anytime Fitness Website/Internet Friend Physician Referral

Magazine/Publication Radio Flier Other

Who lives with you? (please circle all that apply)

Spouse/Partner Children Pets Roommate(s) Other Family Member(s) I live alone

Have you been cleared by your physician to participate in physical activity? YES or NO

If you answered no, you may be asked to obtain clearance from your doctor prior to beginning training.

Health History

Right now, do you have any specific health concerns, such as illness, pain, an/or injury that may impact your ability to participate in physical activity? If yes, please explain.

Have you experienced any health concerns, such as illness, pain, and/or injury in the past 6 months? If yes, please explain.

Are you currently under the care of a physician for a medical condition that will impact your ability to participate in physical activity? If yes, please explain.

Have you recently undergone a medical procedure/operation that may impact your ability to participate in physical activity? If yes, please explain and include date of procedure.

Right now, are you taking any medication, either over the counter or prescription? If yes, please list (including supplements and natural remedies).

Goals

In general, what are your goals? Please circle all that apply.

- | | | |
|------------------------------|-------------------------------|------------------------------|
| Weight/fat loss | Improve balance | Improve flexibility |
| Gain Weight | Improve physical fitness | Look better/feel better |
| Improve athletic performance | Have more energy | Improve self confidence |
| Get stronger/add muscle | Physique competition/modeling | Get control of eating habits |
| Injury prevention | Injury management | Reduce/eliminate pain |

Out of all of the above concerns, which one feels most important/urgent? Why?

Current Fitness Status

Are you regularly active in sports and/or exercise? **YES or NO**

What type of sports/exercise do you typically do?

Please indicate your present attitude towards exercise. (choose one)

1. I hate the thought of exercise and do not currently exercise at all.
2. I'll exercise because I know that I should, but I don't enjoy it.
3. I don't mind exercise, but it isn't a priority.
4. I enjoy exercise and try to be active regularly.

Have you tried anything in the past to change your habits, your health, your eating, and/or your body? If so, what?

Which of those things worked well for you (Even if you might not be doing it right now)? Why?

What are your current social and/or family commitments that impact your schedule and/or ability to exercise?

Disclaimer

During your exercise program, every effort will be made to assure your safety. However, as with any exercise program, there are risks, including increased heart stress and the change of musculoskeletal injuries. In volunteering for this program, you assume responsibility for these risks and waive any possibility for personal damages. You also agree that, to your knowledge, you have no limiting physical conditions or disability that would preclude you from an exercise program. If you do have any medical issues that may be of concern, you further agree that a physician has cleared you to participate in a training and nutrition program.

A physician's examination is recommended for (1) all participants with any exercise restrictions; (2) all men > 44 years old and all women > 54 years old. Coaching participants in either or both of these categories who do not have prior physician examination **MUST** acknowledge they have been informed of its importance. By signing below, you accept full responsibility for your own health and well-being, and you acknowledge an understanding that the leaders of this program assume no responsibility.

Please recognize that it is your responsibility to work directly with your health care provider before, during, and after seeking nutrition and/or fitness consultation. Any information provided is not to be followed without prior approval or your doctor. If you choose to use this information without such approval, you agree to accept full responsibility for your decision.

I acknowledge that I have read and understand the above disclaimer.

Client Signature: _____

Parent/Guardian signature (if participant is a minor): _____

Date: _____

Diet

Disclaimer

In the state of North Carolina, Personal Trainers are not allowed to give nutritional guidance. Because of this, we have a Registered Dietitian on staff who is able to council you with your nutritional goals. If you would like an individualized nutritional assessment, we are in-network with most insurance companies.

Are you interested in having a conversation with our Registered Dietitian? **YES or NO**

If yes, who is your insurance provider?

Blue Cross Blue Shield

Cigna

Tricare

Aetna

Humana

Medicare

Medcost

United

Other

If yes, what would you like to gain from meeting with a dietitian? What health and/or nutrition concerns would you like to focus on?

Have you seen a dietitian before? **YES or NO**

If yes, was it within the past 12 months? **YES or NO**

Have you ever been told by a doctor that you have diabetes? **YES or NO**

If yes, at what age? _____

Have you ever had diabetic education by a Certified Diabetic Educator or a dietitian? **YES or NO**

What has been your:

Lowest Weight? _____ At what age? _____

Highest Weight? _____ At what age? _____

What is your weight goal? **Weight Loss or Weight Gain or Weight Maintenance**

Have you ever been told by a doctor to follow a specific nutrition plan? **YES or NO**

Are you currently following a nutrition plan (i.e. diabetic, gluten free, low lactose, low cholesterol, etc.)? **YES or NO**

If yes, please describe:
