Personal Trainer

Forms Kit

Diet Questionnaire

The following questionnaire is designed to increase your knowledge and awareness of your overall diet, and to highlight potential areas of concern.

1. Do you drink enough fluids so that your urine is a pale yellow color? Yes ☐ No ☐

2. Do you try special or fad diets? Yes ☐ No ☐

3. Do you add salt to foods during cooking at the table? Yes ☐ No ☐

4. Do you minimize your intake of sweets, especially candy and soft drinks, and avoid adding sugar to foods? Yes ☐ No ☐

5. Is your diet well-balanced (including vegetables, fruits, breads, cereals, dairy products, and adequate sources of protein)? Yes ☐ No ☐

6. Do you limit your intake of saturated fats (butter, cheese, cream, fatty meats)? Yes ☐ No ☐

7. Do you limit your intake of cholesterol (eggs, liver, meats)? Yes ☐ No ☐

8. Do you eat fish and poultry more often than red meats? Yes ☐ No ☐

9. Do you eat high-fiber foods (vegetables, fruits, whole grains) several times at day? Yes ☐ No ☐

Exercise Questionnaire

The following exercise questionnaire is designed to increase your knowledge and awareness of your overall exercise activities, and to highlight potential areas of concern.

1. Do you exercise or play a sport for at least thirty minutes three or more time a week? Yes ☐ No ☐

2. Do you warm up and cool down by stretching before and after exercising? Yes ☐ No ☐

3. Do you fall into the appropriate weight category for someone your height and gender? Yes ☐ No ☐

4. In general, are you pleased with the condition of your body? Yes ☐ No ☐

5. Are you satisfied with your current level of energy? Yes ☐ No ☐

6. Do you use the stairs rather than escalators of elevators whenever possible? Yes ☐ No ☐

Medical History Form

Name: ____________________________________ Date: _________________________________

Telephone: ________________________________

Date of Birth:_______ Age: _________ Height: ______________ Weight:___________

In Case of Emergency Contact: ______________________________ Relationship:_____________

Address: ______________________________ Phone: _______

Physician: ______________________________ Specialty: _______

Address: _______ Phone: _______

Are you currently under a doctor's care: Yes ☐ No ☐

If yes, explain: ______________________________

When was the last time you had a physical examination? ______________________________

Have you ever had an exercise stress test: Yes ☐ No ☐ Don't know ☐

If yes, were the results: Normal ☐ Abnormal ☐

Do you take any medications on a regular basis? Yes ☐ No ☐

If yes, please list medications and reasons for taking: ______________________________

Have you been recently hospitalized? Yes ☐ No ☐

If yes, explain: ______________________________

Do you smoke? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

Do you drink alcohol more than three times/week? Yes ☐ No ☐

Is your stress level high? Yes ☐ No ☐

Are you moderately active on most days of the week? Yes ☐ No ☐

Do you have:

High blood pressure? Yes ☐ No ☐

High cholesterol? Yes ☐ No ☐

Diabetes? Yes ☐ No ☐

Have parents or siblings who, prior to age 55 had:

A heart attack? Yes ☐ No ☐

A stroke? Yes ☐ No ☐

High blood pressure? Yes ☐ No ☐

High cholesterol?	Yes ☐	No ☐
Known heart disease?	Yes ☐	No ☐
Rheumatic heart disease?	Yes ☐	No ☐
A heart murmur?	Yes ☐	No ☐
Chest pain with exertion?	Yes ☐	No ☐
Irregular heart beat or palpitations?	Yes ☐	No ☐
Lightheadedness or do you faint?	Yes ☐	No ☐
Unusual shortness of breath?	Yes ☐	No ☐
Cramping pains in legs or feet?	Yes ☐	No ☐
Emphysema?	Yes ☐	No ☐
Other metabolic disorders (thyroid, kidney, etc.)?	Yes ☐	No ☐
Epilepsy?	Yes ☐	No ☐
Asthma?	Yes ☐	No ☐
Back pain: upper, middle, lower?	Yes ☐	No ☐
Other joint pain (explain on back of form)?	Yes ☐	No ☐
Muscle pain or an injury (explain on back of Form)?	Yes ☐	No ☐

To the best of my knowledge, the above information is true.

Signature ____________________________

Date____________________________ Witness ____________________________

Medical Release of Information Form

TO WHOM IT MAY CONCERN:

Please furnish to ___________________________________(hereinafter “Facility”) and/or any or all of its personnel, information, copies of any and all hospital and medical record or reports of any sort, charts, notes, x-rays, lab reports and prescription information, including the right to inspect and coy such records. Facility is to be furnished any and all other information without limitation pertaining to any confinement, examination, treatment or condition of myself, including medical, dental, psychological or other treatment, examinations, or counseling for any condition, medical, dental or psychological.

This AUTHORIZATION shall be considered as continuing and you may rely upon it in all respects unless you have previously been advised by men in writing to the contrary. It is expressly understood by the undersigned and you are hereby authorized to accept a copy of photocopy of this medical authorization with the same validity as though an original had been presented to you.

Dated this:_____________________day of_____________, 20____________

Signature: ____

Name: ____

Address: ____

____

Phone: ________________________ Email:__________________________

Exercise Consent Form

I, the undersigned, hereby expressly and affirmatively state that I wish to participate in ______________________________. I realize that my participation in this activity involves risks of injury, including but not limited to (list) ____ and even the possibility of death. I also recognize that there are many other risk of injury, including serious disabling injuries, which may arise due to my participation in this activity and that it is not possible to specifically list each and every individual injury risk. However, knowing the material risks and appreciating knowing and reasonably anticipating that other injuries and even death are a possibility, I hereby expressly assume all of the delineated risk of injury, all other possible risks of injury and even death which could occur by reason of my participation.

I have had an opportunity to ask questions. Any questions which I have asked have been answered to my complete satisfaction. I subjectively understand the risk of my participation I this activity, and knowing and appreciating these risks I voluntarily choose to participate, assuming all risk of injury or even death due to my participation.

_______________________ _____________________________________

Witness Participant

Date _________________________

NOTE OF QUESTIONS AND ANSWERS

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This is as stated, a true and accurate record of what was asked and answered.

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Participant