

I am not physically active  
I am physically active 1-2 times a week  
I am physically active 3-4 times a week  
I am physically active 5-7 times a week  
I find exercising enjoyable  
I enjoy cardio exercises  
I enjoy strength training

I prefer to work out alone

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I enjoy the following activities:

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Please don't make me do:

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### **Family History**

Is there a family history of the following conditions?

	Yes	No
Cancer		
High Cholesterol		
High Blood Pressure		
Diabetes		
Heart Attack		
Stroke		
Other (please indicate):		

In the space below, please indicate anything that may impact training that is related to family history.

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### **Medical Conditions**

Have you experienced any of the following?

	Yes	No
Physically Inactive (active less than 30 minutes 3 times a week)		
Overweight		
High Cholesterol		
High Blood Pressure		
Stroke		
Heart Surgery		
Other Surgeries		
Other (please indicate):		

### **Medications**

Are you currently taking any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list the medication and identify the condition for which it is taken if it might impact your training program.

<b>Medication:</b> _____	<b>Condition:</b> _____
<b>Medication:</b> _____	<b>Condition:</b> _____
<b>Medication:</b> _____	<b>Condition:</b> _____
<b>Medication:</b> _____	<b>Condition:</b> _____

**Allergies**

Do you have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list the allergy and identify any medication required to be taken.

<b>Allergy:</b> _____	<b>Medication:</b> _____
<b>Allergy:</b> _____	<b>Medication:</b> _____

Please provide additional information regarding medications taken, conditions and allergies, if necessary.

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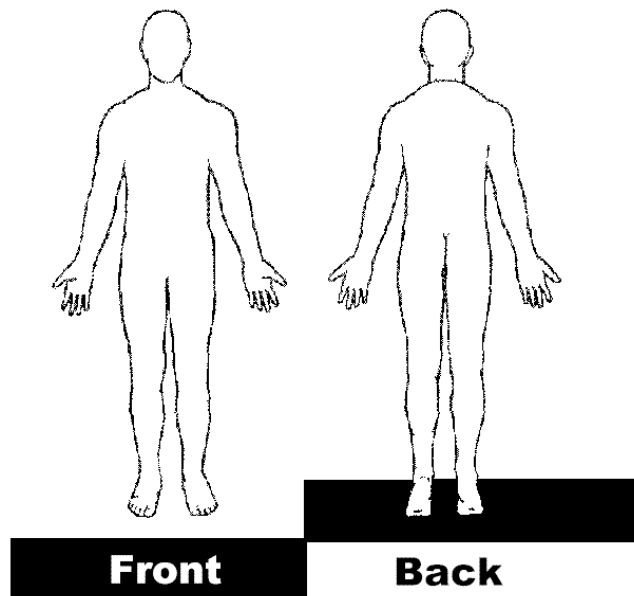
**Pain and/or Injuries**

Do You Experience Any Pain or Do You Have Any Current or Previous Injuries?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please circle the location of the pain or injury.

Have you ever had an accident or a surgery that may impact your training program: (e.g. broken hip)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe and explain.



### Goals

What are your fitness goals/what do you want to get out of the sessions (lose weight, increase strength, improve technique, have someone to motivate me etc.)

What will help motivate you to reach your goals?

### Personal Trainer

What equipment do you hope to use?

What day and time of the week works best for your schedule?

Machines in weight room  
Free weights (barbells) in weight room  
Balls/bands/smaller weights  
Indoor Track  
Functional Equipment (sleds, sandbags)  
Pool  
Outdoor  
Doesn't matter to me

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
morning							
afternoon							
evening							

What type of trainer do you want/what works best for you?

Someone who is upbeat  
Someone who will push/encourage me  
Someone the similar age to me  
Someone who will let me work at my own pace


What would you like your training schedule to be?

(ie: How many sessions do you want to do? do you want to do regular, ongoing sessions or sporadic timing? Do you want to do a set number of sessions? Etc.)

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Is there a specific trainer that you wish to be paired with? \_\_\_\_\_

Is there any other information that will help us in designing your program or pairing you with a trainer?

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**Contact In Case of Emergency**

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

**Family Physician/Medical Professional**

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

**Client**

By signing this form, I certify that I have disclosed all pertinent information in an honest and truthful manner. **I also understand that cancelling with less than 24 hours' notice will result in a charge for the scheduled session.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

To return this form, drop it off at the Reception Desk of the Bracebridge Sportsplex or scan and email to [rec.office@bracebridge.ca](mailto:rec.office@bracebridge.ca) or [L.Roberge@bracebridge.ca](mailto:L.Roberge@bracebridge.ca) and someone will contact you.