

Personal Training Pre-exercise Consultation Form

Please complete this form prior to your first session. Email completed form to EvolvME at info@evolvme.com.au or post to: EvolvME PO Box 991 North Adelaide SA 5006.

Surname	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	
<p><i>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:</i></p> <ol style="list-style-type: none"> 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 <p>If you answered YES to any of these questions please seek guidance from your GP or make an appointment to see one of our Exercise Physiologists prior to undertaking physical activity/exercise with our Personal Trainer.</p> <p>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.</p>	

Please state your:		
Height?	_____	cm
Weight?	_____	kg
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?		
<input type="checkbox"/> Less than 4 glasses <input type="checkbox"/> 4-6 glass <input type="checkbox"/> 6-8 glasses <input type="checkbox"/> 8+ glasses		
How much sleep do you get per night?		
<input type="checkbox"/> Less than 4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-9 hours <input type="checkbox"/> 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?		
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? _____		
Type?		

<p>Do you enjoy exercise? What exercise do you enjoy doing the most?</p>
<p>How many days per week are you prepared to exercise (either with a personal trainer or on your own)?</p>
<p>What are your reasons for engaging a personal trainer?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Weight Loss <input type="checkbox"/> Improve fitness <input type="checkbox"/> Change the way you look or feel about your body <input type="checkbox"/> Medical or health reasons <input type="checkbox"/> Referred by GP/allied health professional <input type="checkbox"/> Stress <input type="checkbox"/> Other, please state
<p>What would you like to achieve with the help of a personal trainer?</p>
<p>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?</p>
<p>Why is this important to you?</p>
<p>What barriers can you see that may inhibit you from achieving these goals?</p>
<p>On a scale of 1-10 (1 being least & 10 being most) how important is it that you achieve these goals?</p>
<p>What's your diet like? Do you require advice or assistance with your diet from one of our Accredited Dietitians?</p>

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

- Massage Therapy
- Diabetes Educator
- Dietitian
- Exercise Physiologist
- Nutrition Seminars
- Small Group Personal Training
- Personal Training
- Mums 'n Bubs Small Group Personal Training
- Individualised 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 EvolvME for statistical data collection.
- I do not wish to be included on EvolvME's email list.