Personal Training Consultation Form

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| Athlete’s Name: | DOB: | Age: |
| Phone Number: | Email: | Grade: |
| Address: |
| Emergency Contact: | Relationship: |
| Phone Number: | Phone Number: |
| Reason for training: |
| Type of training:[ ]  IPT [ ]  SGAT | SGAT only: [ ] Set Group Members [ ] Need Group Members |
| How often would you like to train: Days/Week | Training History: |

 **Medical History:**

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| --- | --- | --- |
| Date of Last Physical: | Height: | Weight: |
| Physicians Name: | Phone Number: |
| Please Check Any Current or Past Conditions:

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| [ ]  Heart Attack, Coronary Bypass, Cardiac Surgery or Stroke |
| [ ]  Abnormal Resting or Stress ECG or Heart Murmur |
| [ ]  Irregular Heart Beats (Including a Racing or Fluttering Heart) |
| [ ]  High Cholesterol  |
| [ ]  Diabetes  |
| [ ]  High Blood Pressure (≥ than 140 mmHg over 90 mmHg) |
| [ ]  Phlebitis (Deep Vein Thrombophlebitis) |
| [ ]  Pulmonary Disease (Asthma, Emphysema and Bronchitis) |

 [ ]  Epilepsy  **[ ]** Allergies (Bees, Food, Latex, etc) [ ] Pregnant [ ]  Smoker [ ]  Ex-smoker [ ]  Alcohol use (excessive) |  [ ]  Caffeine use (excessive)

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| [ ]  Headaches/Migraines  |
| [ ]  Light Headedness, Fainting or Seizures |
| [ ]  Chest Pain at Rest or Exertion |
| [ ]  Unusual Shortness of Breath |

 **[ ]**  Blood Disorder **[ ]** Metabolic Disorders(Thyroid, Kidney etc)

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| [ ]  Orthopedic Injuries (Arthritis, Bone, Joint**,** Muscle, |

 Surgeries) **[ ]**  Other Conditions not Listed:    |
| Please list all surgeries and hospital stays: |
| Please list all Medications and supplements: |

I acknowledge that I am in good health, have answered the previous questions truthfully, and have no known medical problems that would preclude safe participation in this exercise program. If anything changes within my health status I will notify Design Yourself Strong immediately.

Participant Signature Date

Parent/Guardian Signature (Under 18) Date