Personal Training Consultation Form

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Last Physical: | | Height: | Weight: |
| Physicians Name: | Phone Number: | | |
| Please Check Any Current or Past Conditions:   |  | | --- | | 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)   |  | | --- | | Headaches/Migraines | | Light Headedness, Fainting or Seizures | | Chest Pain at Rest or Exertion | | Unusual Shortness of Breath |   Blood Disorder  Metabolic Disorders(Thyroid, Kidney etc)   |  | | --- | | 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