Perception Fitness

Personal Training Registration

PLEASE PRINT

Name: _____ Date of Birth _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____

Emergency Contact/Phone: _____

Please indicate if you have a family history or experience any of the following health conditions:

___ Abnormal EKG ___ Angina ___ Asthma ___ Diabetes ___ Gout ___ Migraines
___ Heart Attack ___ Heart Disease ___ Hypertension ___ High Cholesterol ___ Stress
___ Other_____

Please indicate if you use the following substances:

___ Dietary Supplements ___ Tobacco Products ___ Other _____

Please indicate and explain any physical impairment or disability that should be considered before you begin personal training..

_____

_____

_____

PERSONAL HEALTH HISTORY

Date of Last Physical Exam:		
List your prescribed drugs and over-the-counter drugs, such as vitamins, herbal supplements and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications, foods, and environmental stimuli		
Allergy	Reaction You Had	

EXERCISE HABITS AND PERSONAL SAFETY	
Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# Of meals you eat in an average day?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# Of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

What are your reasons for wanting to start an exercise program?

What are your goals, and in what time frame? Please be specific

Do you have a time of day you prefer to exercise?

What are you usual leisure activities?

Have you had any previous injuries?

Do you have high blood pressure?	☐ Yes	☐ No
Do you have diabetes?	☐ Yes	☐ No
Do you have a heart condition?	☐ Yes	☐ No
Do you have a family history of heart disease before 55?	☐ Yes	☐ No
Do you have a family history of obesity?	☐ Yes	☐ No
Do you have a history of chest pain?	☐ Yes	☐ No
Have you ever had a stroke?	☐ Yes	☐ No
Have you ever had a heart attack?	☐ Yes	☐ No
Do you have a history of breathing or lung problems?	☐ Yes	☐ No
Do you experience breathlessness after mild energy exertion?	☐ Yes	☐ No
Do you ever have dizzy spells, feel faint, lose your balance, or lose consciousness?	☐ Yes	☐ No
Do you have a thyroid condition?	☐ Yes	☐ No
Have you ever had a hernia, or any other condition that may be aggravated by weightlifting?	☐ Yes	☐ No
Do you have any arthritic conditions?	☐ Yes	☐ No

LIST FOOD/FRUIT/VEGETABLES YOU DO NOT EAT

LIST FOOD/FRUIT/VEGETABLES YOU ARE WILLING TO TRY

LIST FAVORITE FOOD/FRUIT/VEGETABLES

I, _____ , do hereby acknowledge that I am initiating upon this fitness regime of my own free will. I declare that I have no pre-existing conditions that will, in any way, prohibit me from performing the recommended exercises. I recognize that an examination by a physician should be obtained by ALL participants prior to involvement in any exercise program. If I have chosen not to obtain a physician's permission prior to beginning this exercise program with Perception Fitness, I hereby agree that I am doing so at my own risk. I understand that results are individual and may vary. By signing this document I am waiving any right I or my successors might have to bring a legal action or assert a claim for any injury, ailment, or death against Perception Fitness, or that of Perception Fitness assigns, employees, agents, or contractors.

Participant s Signature _____ Date _____

Print Name: _____

If participant is a minor, parents please sign.

Email: bashly13@gmail.com Phone: 512-825-0468