# FITNESS CONSULTATION JOURNAL

EDGE PERSONAL TRAINING

It's Never Too Late To Change Your Life!

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**Welcome to The EDGE! We are proud to offer Chittenden County's most extensive fitness and wellness centers, with 5 locations in the greater Burlington area.**

Congratulations on your decision to pursue a more active, healthier and happier lifestyle. Our PROFITNESS PROGRAM is your guide to accomplishing your short and long-term goals.

Please take the time to review this information and complete the required forms prior to your consultation. This allows us to provide you with an efficient, informative and accurate experience.

At the time of your registration at The EDGE, your membership director will add you into our personal training database for our fitness consultant to contact you. Your membership director will give you a Temporary Membership Card with an expiration of 2 weeks until you are seen by our consultant. Once you have gone through the consultation process you are then an official member. Your fitness consultant will then give you a permanent EDGE swipe card.

On the day of your consultation, please arrive at the club 15-20 minutes prior to your scheduled appointment. You may be performing some exercises and/or assessments so please dress accordingly. Your consultant will meet you at the Front Desk at the time of your appointment.

Upon completion of the consultation (body composition, aerobic capacity, exercise technique & intensity), your consultant will provide you with the appropriate recommendations for the successful achievement of your health and fitness goals. If you have registered for the complete annual consultation program, you will receive emails along with phone calls to remind you every three months to schedule a new appointment.

## <u>Personal Information</u>

Name ________________________ Date ________________________

Consultation Date _______________ Membership Director ____________

Consultant _____________________ Email ________________________

Home Phone ____________________ Work Phone ___________________

Address ____________________________________________________________

City ____________________________ Zip Code _____________________

Occupation ______________________ Employer _____________________

Date of Birth _________ Gender _______ Age ______ Marital Status __________

Physician ________________________ Physician's Phone _______________

Physician's Address _______________________________________________

***Due to insurance guidelines, each member is required to undergo a complete fitness consultation prior to starting a full fitness program.***

## Pre-Consultation Instructions

- Have a light snack 2-3 hours prior to your appointment
- Come ready to exercise: T-Shirt, shorts, gym shoes & towel
- Allow at least 60-90 minutes for your visit
- As exercise & assessments may be performed, limit activity prior to visit
- Be properly hydrated to ensure accurate body fat analysis

## Personal Fitness Profile / History

Are you currently exercising? YES NO
If yes, how long have you been on this routine? ____________________________
What type of exercise(s)? ______________________________________________
_______________________________________________________________________
Frequency _____________________________________________________________
Duration ______________________________________________________________
How many times a week are you able to realistically train for 1 hour ___________

What recreational activities do you participate in? ___________________________
_______________________________________________________________________
_______________________________________________________________________

Are you content with your current physical state? YES NO
Reason ________________________________________________________________

Have you been on a regular fitness routine at a health club in the past?
YES NO Duration ________________________________________________

Have you ever utilized the services of a personal trainer? YES NO
If yes, how long? ________________ If no, why not? _________________________
What are your thoughts about personal training? ___________________________
_______________________________________________________________________

Are you confident in your training knowledge and abilities? YES NO

Do you know how to use free-weights safely and effectively? YES NO

Do you know how to use the selectorized circuit machines (Cybex or Keiser) effectively? YES NO

Are you able to determine the difference between sets and repetitions of an exercise for maximum efficiency? YES NO

Explain ________________________________________________________________
_______________________________________________________________________

What brought you to the decision to enroll with us at The EDGE? _____________
_______________________________________________________________________

# Medical History

Past or present, do any of these conditions relate to you?

## Heart Disease

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Angina Pectoris
☐ Myocardial Infarction ☐ Heart Murmur ☐ Cardiac Arrythmia
☐ Tachycardia ☐ Rheumatic Fever

## Cardiovascular Disease

☐ Arteriosclerosis ☐ Aneurysm ☐ Stroke
☐ Cholesterol ☐ Varicose Veins

## Respiratory Disease & Endocrine Disease

☐ Asthma ☐ Emphysema ☐ Diabetes
☐ Hyperthyroidism ☐Hypothyroidism

## Muscular-Skeletal Disorder

☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis
☐ Tendonitis ☐ Bursitis ☐ Fibromyalgia
☐ Herniated Disc

## Neurological Disorder

☐ Epilepsy ☐ Sciatica ☐ Insomnia ☐ Impingement

## Miscellaneous

☐ Hernia ☐ Anemia ☐ Ulcers ☐ Allergies ☐ Chronic Fatigue Syndrome
☐ Tumor ☐ Cyst ☐ Auto Immune Disorder ☐ Other ____________

Are you currently on any medications? ___________________________________
_____________________________________________________________________
_____________________________________________________________________

Have you ever been treated by: Chiropractor Physical Therapist

When? ________________________ Why? ___________________________

When? ________________________ Why? ___________________________

When? ________________________ Why? ___________________________

Have you had any surgeries or injuries that would need to be considered if put on a program? ____________________________________________________________

______________________________________________________________________

If yes to surgeries or injuries, please list below:

Date of Surgery or Injury ________ Date of Surgery or Injury ________

Recovery Period ________________ Recovery Period ________________

Complications? _________________ Complications? _________________

Are you accustomed to vigorous exercise? YES NO

If yes, what kind? _______________________________________________________

Do you experience the following symptoms prior to, during, or after physical activity?

☐ Muscle Cramps ☐ Dizziness ☐ Neck or Back Pain

☐ Swelling of Joints ☐ Coughing/Nausea ☐ Chest Pain

☐ Shortness of Breath ☐ Headaches/Migraines ☐Grinding Joints

☐ Irregular Bowel Movements

Can the above pain or discomfort be described as:

☐ Dull Ache ☐ Sharp, Shooting, Searing ☐ Numbness or Tingling

Is there any other physical reason (not mentioned) why you should not follow an exercise program? _____________________________________________________

When was your last physical or doctors visit? ______________________________

## Injuries

**Do you have any current or day-to-day pain in the following areas?**

| | YES | NO | Mild | Moderate | Extreme | Left | Right |
|---|---|---|---|---|---|---|---|
| Neck | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Shoulder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arm | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Forearm | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Wrist | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chest | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Upper Back | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lower Back | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Abdominals | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hip | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Leg | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Knee | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Foot | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Other? ____________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

## Wellness

Do you consume caffeine regularly and how much?

Do you use tobacco products?

Do you drink alcohol regularly, and if so, how much?

Do you get 6-8 hours of sleep every night?

Would you classify your sleep as restful?

Do you stretch regularly after workouts?

Do you have a sedentary job?

Are you overly stressed?

If yes, how do you relieve stress?

Do you overeat or eat fastfood due to stress, unhappiness or lack of time?

Do you feel in control of your nutritional and exercise choices?

Do you possess background knowledge in the following categories:

☐ Nutrition ☐ Competitive Running ☐ Bodybuilding

☐ Yoga ☐ Cardiovascular Conditioning ☐ Weight Training Principles

## Nutrition

*The following section deals with the nutrition components of your training program. By answering all of these questions honestly, we will get a better idea of the areas that you most need to focus on.*

Do you have any specific questions regarding your nutritional habits?

Are you interested in speaking with our nutrition experts who can help you formulate a nutrition plan specifically for your needs?

| **Nutritional Profile** | **Always** | **Sometimes** | **Never** |
|---|---|---|---|
| Do you consistently eat 3-5 meals per day? | ☐ | ☐ | ☐ |
| Do you eat breakfast daily? | ☐ | ☐ | ☐ |
| Do you use vitamin or mineral supplements? | ☐ | ☐ | ☐ |
| If yes, what brand? __________ | | | |
| Do you use a protein supplement? | ☐ | ☐ | ☐ |
| Do you follow a Vegetarian Diet? | ☐ | ☐ | ☐ |
| Do you drink at least 8 glasses of water daily? | ☐ | ☐ | ☐ |

Have you ever purchased any products to help you lose weight? YES NO

If yes, what type? ____________________________________________________

**Could you please provide your typical day's worth of food choices at each meal as well as your ideal day:**

## Typical Day

Breakfast

Snack (Mid-Morning)

Lunch

Snack (Mid-Afternoon)

Dinner

Snack (Late-Evening)

## Ideal Day

Breakfast

Snack (Mid-Morning)

Lunch

Snack (Mid-Afternoon)

Dinner

Snack (Late-Evening)

## Results You Wish To Achieve

☐ Weight Training ☐ Aerobic Capacity ☐ Muscle Toning ☐ Bodybuilding
☐ Flexibility ☐ Intensity Training ☐ Sport-Specific Conditioning
☐ Nutrition ☐ Stress Management ☐ Knowledge/Education
☐ Weight Loss ☐ Other ___________________________________________

In your own words, please tell us what you hope to achieve at our club in the first 3 months:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

In your first 6 months:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

In your first year:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**HOW CAN WE HELP YOU REACH YOUR GOALS?**

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

*Your consultant will review all of your answers with you. From your answers and consultation results, you will be advised as to the most effective and beneficial route for you to attain your state health and fitness goals.*

## Measurements, Assessments & Recommendations

**Name** ______________________________ **Age** ________ **Date** ____________

| Measurements | #1 | #2 | #3 | #4 | Goal |
|---|---|---|---|---|---|
| Body Weight | | | | | |
| Height | | | | | |
| Resting Blood Pressure | | | | | |
| Resting Heart Rate | | | | | |
| **Measurements** | **#1** | **#2** | **#3** | **#4** | **Goal** |
| Body Fat % | | | | | |
| Pounds of Fat | | | | | |
| Lean Body Mass | | | | | |
| Pounds of LBM | | | | | |
| **Measurements** | **#1** | **#2** | **#3** | **#4** | **Goal** |
| Neck | | | | | |
| Shoulders | | | | | |
| Chest | | | | | |
| Arm at Side - R | | | | | |
| Arm at Side - L | | | | | |
| Arm Flexed - R | | | | | |
| Arm Flexed - L | | | | | |
| Waist | | | | | |
| Hips | | | | | |
| Thigh - R | | | | | |
| Thigh - L | | | | | |
| Calf - R | | | | | |
| Calf - L | | | | | |

| Assessments | #1 | #2 | #3 | #4 | Goal |
|---|---|---|---|---|---|
| Push Ups | | | | | |
| Wall Sits | | | | | |
| Floor Plank | | | | | |
| 3-Minute Step Test | | | | | |
| Flexibility | | | | | |

## Fitness Consultant Recommendations

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|---|
| Strength Training | | | | | | | |
| Cardio | | | | | | | |
| Flexibility | | | | | | | |
| Day Off | | | | | | | |

*ACSM Guidelines for Exercise*

*Cardiovascular Training - Adults should get at least 150 minutes of moderate-intensity exercise per week.*

*Strength Training - Adults should train each major muscle group two or three days each week using a variety of exercises and equipment.*

*Flexibility Training - Adults should do flexibility exercises at least two or three days each week to improve range of motion.*