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(949) 829-4589

The completion of this form will be used to help develop a plan that will best meet your needs and help you to safely achieve your goals. This information is entirely confidential- as are all your sessions.
Thank you for your time and for sharing this information.

PRE-CONSULTATION QUESTIONNAIRE (PLEASE PRINT)	
FIRST NAME:	
LAST NAME:	
GENDER:	☐ MALE ☐ FEMALE
BIRTHDATE: (M/D/Y)	
STREET ADDRESS:	
CITY:	
STATE:	
ZIP:	
TELEPHONE: (Mobile)	
EMAIL:	
EMERGENCY CONTACT:	
EMERG. CON. TELEPHONE:	
EMERG. CON. RELATION:	
Referred by:	
OR did you hear about us via:	☐ Google ☐ Mailer ☐ Yelp! ☐ Facebook
☐ Other:	

HEALTH GOALS

1. Please check all the goals you would like to achieve:

☐ Accountability	☐ Look Better	☐ Increase Flexibility	☐ Lose Weight
☐ Build Confidence	☐ Improve Nutrition	☐ Increase Muscle Mass	☐ Maintain Weight
☐ Build Strength	☐ Improve Health Markers (i.e. Blood Pressure)		☐ Gain Weight
☐ Other:			

2. Are there any barriers to achieving these goals? If YES, please describe. ☐ Yes ☐ No

3. On a scale of 1-10, how important are these goals to you?		
4. On a scale of 1-10, how important is it to reach your goals?		
5. On a scale of 1-10, how confident are you that you will reach these goals?		
6. Please check all areas of specialty training that interest you:		
☐ Weight Training	☐ TRX	☐ Stick Mobility
☐ Kick Boxing	☐ Self Defense	☐ HIIT (High Intensity Interval Training)

MEDICAL INFORMATION

7. How would you describe your health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
8. Are you taking any prescription, over-the-counter medications, dietary herbs or supplements? (If YES, please list name and reason)	☐ Yes ☐ No
9. When was the last time you visited your physician?	
10. Do I have permission to communicate with your physician?	☐ Yes ☐ No
PHYSICIAN NAME:	
PHYSICIAN TELEPHONE:	

11. Do you have or has your doctor or another licensed healthcare professional told you that you have any of the following conditions?

☐ Allergies (specify):	☐ Diabetes
	☐ Disordered eating
☐ Amenorrhea or absence of menstrual period >3 months	☐ Gastroesophageal reflux disease (GERD)
☐ Anemia	☐ High blood pressure/hypertension
☐ Anxiety	☐ High cholesterol
☐ Arthritis	☐ Hyper/hypothyroidism
☐ Asthma	☐ Hypoglycemia
☐ Cancer	☐ Insomnia
☐ Cardiovascular disease	☐ Intestinal problems
☐ Celiac disease	☐ Irritable bowel syndrome
☐ Chronic sinus condition	☐ Osteoporosis
☐ Cigarette smoker	☐ Polycystic ovary disease
☐ Crohn's disease	☐ Pregnant or<3 months postpartum
☐ Depression	☐ Skin problems (describe):

Past Surgeries (describe):

Past Injuries (describe):

12. Has anyone in your family been diagnosed with any of the following? If YES, please describe:

DIAGNOSIS	RELATIONSHIP (e.g. father)	AGE OF DIAGNOSIS
☐ Heart Disease		
☐ High Cholesterol		
☐ High Blood Pressure		
☐ Cancer		
☐ Diabetes		
☐ Osteoporosis		

NUTRITION HISTORY

13. Have you ever followed a modified diet to manage a health condition? ☐ Yes ☐ No

If YES, please describe:

14. Do you follow a specialized diet (low carb, gluten-free, vegan, etc.)? ☐ Yes ☐ No

If YES, please describe diet and reasons for following:

15. Was the diet prescribed by a health professional? ☐ Yes ☐ No

16. Who purchases and prepares your food?

17. How many times a week do you eat out (i.e. restaurants, fast food)?

18. Have you ever tracked your food on a smartphone app (i.e. Cronometer, MyFitnessPal)?

19. How many ounces of water do you drink a day (estimate)?

PHYSICAL ACTIVITY HISTORY

20. Are you currently physically active? If YES, please describe: ☐ Yes ☐ No

21. Please list your favorite physical activities:

fitness coach

WEIGHT HISTORY			
22. What would you like to do regarding your weight?	☐ Lose ☐ Maintain ☐ Gain		
23. What was your lowest weight in the past five years?		Your highest?	
24. What is your current weight?		What is your height?	

OTHER
Is there any other information that you think I should know? Please use this space:

TO BEST ACCOMMODATE ALL OUR CLIENTS AND TRAINERS SCHEDULES PLEASE CHECK <u>ALL TIMES</u> YOU ARE AVAILABLE FOR TRAINING.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
AM 5:00 ☐	AM 5:00 ☐	AM 5:00 ☐	AM 5:00 ☐	AM 5:00 ☐	AM 5:00 ☐
6:00 ☐	6:00 ☐	6:00 ☐	6:00 ☐	6:00 ☐	6:00 ☐
7:00 ☐	7:00 ☐	7:00 ☐	7:00 ☐	7:00 ☐	7:00 ☐
8:00 ☐	8:00 ☐	8:00 ☐	8:00 ☐	8:00 ☐	8:00 ☐
9:00 ☐	9:00 ☐	9:00 ☐	9:00 ☐	9:00 ☐	9:00 ☐
10:00 ☐	10:00 ☐	10:00 ☐	10:00 ☐	10:00 ☐	10:00 ☐
11:00 ☐	11:00 ☐	11:00 ☐	11:00 ☐	11:00 ☐	11:00 ☐
PM 12:00 ☐	PM 12:00 ☐	PM 12:00 ☐	PM 12:00 ☐	PM 12:00 ☐	PM 12:00 ☐
1:00 ☐	1:00 ☐	1:00 ☐	1:00 ☐	1:00 ☐	1:00 ☐
2:00 ☐	2:00 ☐	2:00 ☐	2:00 ☐	2:00 ☐	2:00 ☐
3:00 ☐	3:00 ☐	3:00 ☐	3:00 ☐	3:00 ☐	3:00 ☐
4:00 ☐	4:00 ☐	4:00 ☐	4:00 ☐	4:00 ☐	4:00 ☐
5:00 ☐	5:00 ☐	5:00 ☐	5:00 ☐	5:00 ☐	5:00 ☐
6:00 ☐	6:00 ☐	6:00 ☐	6:00 ☐	6:00 ☐	6:00 ☐
7:00 ☐	7:00 ☐	7:00 ☐	7:00 ☐	7:00 ☐	7:00 ☐

FIRST INITIAL & LAST NAME _____