



FITNESS CONSULTATION

** After contacting a trainer, please print, complete, and send this form along with a check in the amount of \$55 payable to **Reshape**, LLC to the address on the bottom of this page **

Name: _____ Date: _____
Phone number: _____ E-Mail: _____
Street Address: _____ City: _____ Zip Code: _____
Age: _____ HT: _____ WT: _____ lbs Gender: M / F

Please check the health benefits and objectives that are most meaningful to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> lower blood pressure | <input type="checkbox"/> lower cholesterol | <input type="checkbox"/> lower stress level |
| <input type="checkbox"/> improve posture | <input type="checkbox"/> look better | <input type="checkbox"/> feel better |
| <input type="checkbox"/> higher energy levels | <input type="checkbox"/> increased flexibility | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> strengthen upper body | <input type="checkbox"/> strengthen lower body | <input type="checkbox"/> strengthen trunk |
| <input type="checkbox"/> reduce waist measurement | <input type="checkbox"/> reduce % body fat | <input type="checkbox"/> add lean tissue |
| <input type="checkbox"/> reduce general/joint pain | <input type="checkbox"/> special event preparation | <input type="checkbox"/> fit into wardrobe |

Health & Fitness Goals:

Specific areas of the body to focus on:

Realistically, how many days of the week will you dedicate to working out on your own?

How much time are you willing to dedicate per week to personal training at **Reshape**?

Do you have a membership at a local gym, and if so, where?

Exercise habits over the past twelve months:

Athletic and/or active interests:



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Are you currently or have you previously worked with a personal trainer?

Eating habits. Are you on any diets? If so, please explain.

Do you eat breakfast? If so, please describe.

How often do you eat?

Describe your level of activity in an average day.

Check all conditions that apply to you:

- | | | |
|--|---|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> fatigue | <input type="checkbox"/> knee problems |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> bursitis | <input type="checkbox"/> shoulder problems |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> muscle tension | <input type="checkbox"/> tendon/joint problems |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> anxiety | <input type="checkbox"/> back problems |

Additional medical problems or challenges?

Medication that you are currently taking:

Injuries impacting your ability to perform exercises:

THIS SECTION TO BE FILLED OUT BY A TRAINER

Tape Measurements (inches)

Chest: _____ Upper Arm: _____ Waist: _____ Hips: _____ Thigh: _____ Calf: _____

Sit & Reach: _____ in.

Skinfold Measurements (mm)

Triceps _____ Biceps _____ Subscapular _____ Suprailiac _____
Total _____ %bf _____