The Corporation of the Town of Bracebridge
RECREATION DEPARTMENT
Personal Training - Intake Form

NAME: _____

ADDRESS: _____

CELL PHONE : _____ **ALT PHONE:** _____

DATE OF BIRTH: _____ **E-MAIL:** _____

Please complete the following questionnaire to be shared confidentially with your trainer.

Lifestyle

	Always	Sometimes	Rarely/Never
I get 6-8 hours of sleep per night			
I have regular medical checkups			
I am highly motivated and determined			
I have a busy work schedule			
I have a busy home schedule			
I journal food and exercise			
I am a smoker			
I feel stressed			

Diet

	Always	Sometimes	Rarely/Never
I eat mainly pre-prepared foods			
I drink enough water every day			
I enjoy a variety of foods daily (fruit, vegetables, protein, fats)			
I like to prepare my own food			
I limit my sugar intake			
I like to eat out			
I skip meals			

Do you currently follow a specific eating program? Yes _____ No _____

If yes, please explain (i.e. gluten free, vegetarian etc.)

_____

_____

Exercise Habits:

	Yes	No
I am not physically active		
I am physically active 1-2 times a week		
I am physically active 3-4 times a week		
I am physically active 5-7 times a week		
I find exercising enjoyable		
I enjoy cardio exercises		
I enjoy strength training		

I prefer to work out alone		

I enjoy the following activities:

_____

Please don't make me do:

_____

Family History

Is there a family history of the following conditions?

	Yes	No
Cancer		
High Cholesterol		
High Blood Pressure		
Diabetes		
Heart Attack		
Stroke		
Other (please indicate):		

In the space below, please indicate anything that may impact training that is related to family history.

_____

_____

Medical Conditions

Have you experienced any of the following?

	Yes	No
Physically Inactive (active less than 30 minutes 3 times a week)		
Overweight		
High Cholesterol		
High Blood Pressure		
Stroke		
Heart Surgery		
Other Surgeries		
Other (please indicate):		

Medications

Are you currently taking any medications? Yes _____ No _____

If yes, please list the medication and identify the condition for which it is taken if it might impact your training program.

Medication: _____ **Condition:** _____

Medication: _____ **Condition:** _____

Medication: _____ **Condition:** _____

Medication: _____ **Condition:** _____

Allergies

Do you have any allergies? Yes _____ No _____

If yes, please list the allergy and identify any medication required to be taken.

Allergy: _____ **Medication:** _____

Allergy: _____ **Medication:** _____

Please provide additional information regarding medications taken, conditions and allergies, if necessary.

_____

_____

_____

_____

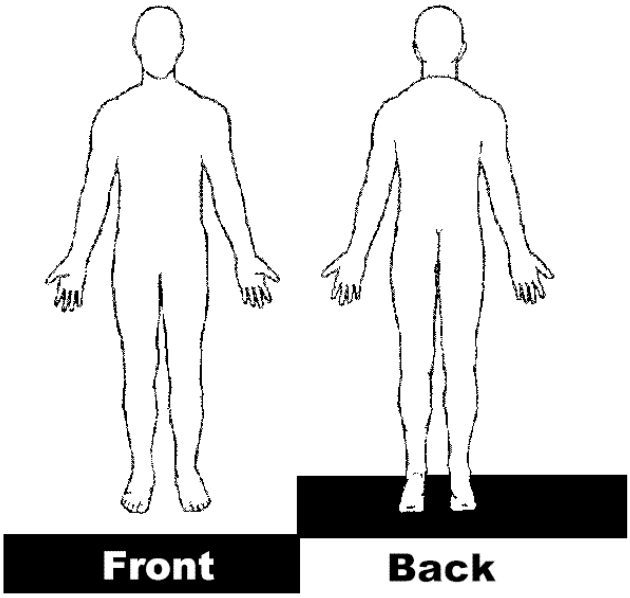
Pain and/or Injuries

Do You Experience Any Pain or Do You Have Any Current or Previous Injuries?

Yes _____ No _____ If yes, please circle the location of the pain or injury.

Have you ever had an accident or a surgery that may impact your training program: (e.g. broken hip)? Yes _____ No _____

If yes, please describe and explain.



The Corporation of the Town of Bracebridge
RECREATION DEPARTMENT
Personal Training - Intake Form

Goals

What are your fitness goals/what do you want to get out of the sessions (lose weight, increase strength, improve technique, have someone to motivate me etc.)

What will help motivate you to reach your goals?

Personal Trainer

What equipment do you hope to use?

What day and time of the week works best for your schedule?

Machines in weight room	
Free weights (barbells) in weight room	
Balls/bands/smaller weights	
Indoor Track	
Functional Equipment (sleds, sandbags)	
Pool	
Outdoor	
Doesn't matter to me	

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
morning							
afternoon							
evening							

What type of trainer do you want/what works best for you?

Someone who is upbeat	
Someone who will push/encourage me	
Someone the similar age to me	
Someone who will let me work at my own pace	

What would you like your training schedule to be?

(ie: How many sessions do you want to do? do you want to do regular, ongoing sessions or sporadic timing? Do you want to do a set number of sessions? Etc.)

Is there a specific trainer that you wish to be paired with? _____

Is there any other information that will help us in designing your program or pairing you with a trainer?

Contact In Case of Emergency

NAME: _____

RELATIONSHIP: _____

HOME PHONE: _____ **CELL PHONE:** _____

Family Physician/Medical Professional

NAME: _____

PHONE: _____

Client

By signing this form, I certify that I have disclosed all pertinent information in an honest and truthful manner. **I also understand that cancelling with less than 24 hours' notice will result in a charge for the scheduled session.**

Signature: _____ **Date:** _____

To return this form, drop it off at the Reception Desk of the Bracebridge Sportsplex or scan and email to rec.office@bracebridge.ca or ajames@bracebridge.ca and someone will contact you.