

COR Fitness Request for Personal Training Sessions

Name: _____ Age: _____

Phone: _____

Email: _____
Email address is required.

Preferred Trainer (if you have one): _____

What are your preferred days and times for training?

- Mornings Afternoon Evening

Days available: _____

MFC Desk Staff: **VERIFY MEMBERSHIP** Complete the section below and put on **Jenel Shepherd's** desk.

This is for Membership- Complimentary 1 Hour/calendar year Paid Training Sessions # _____ (30/60 min)

Staff Completing Form: _____ Date: _____

Personal Training Tracking Agreement – Please Check In Before Each Session

Training Session #	Session Date/Time	Client Initials	Front Desk Initials	Trainer Initials
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

HEALTH HISTORY QUESTIONNAIRE

Answer each question by printing the necessary information. Your answers are confidential.

PERSONAL INFORMATION

Name: _____ Date of birth: _____ Age: _____

Phone: _____ Alternate Phone: _____

Email: _____

In case of emergency please notify:

Name: _____ Relationship: _____

Phone: _____

MEDICAL INFORMATION

Are you under the care of a physician, chiropractor or other health care professional for any reason?

Yes No

If yes, list reason: _____

Are you taking any medications? Yes No

Type	Dosage/Frequency	Reason for taking
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_____	_____	_____
_____	_____	_____

Please list any allergies: _____

Has your doctor ever said your blood pressure was too high? Yes No

Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?

Yes No

Is there any reason not mentioned here why you should not follow a regular exercise program?

If so, please explain: _____

Do you smoke? Yes No

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain or general discomfort:

Head / Neck: _____

Upper Back: _____

Shoulder / Clavicle: _____

Arm / Elbow: _____

Wrist / Hand: _____

Lower Back: _____

Hip / Pelvis: _____

Thigh / Knee: _____

Arthritis: _____

Hernia: _____

Surgeries: _____

Other: _____