

Sports & Fitness
EDGE



Fitness Consultation Journal

Consultation Date: _____

Fitness Consultant: _____

Your Consultant's Contact Info: _____

There is a \$25 No-Show Cancellation Fee if you cancel under 8 business hours of the time of your booked appointment. Please call your consultant ahead of time to reschedule.



Table of Contents

Step by Step Guide to the ProFitness Program	2
Personal Information / Pre- Consultation Instructions	3
A: Personal Fitness Profile / History	4
B: Medical History.....	5-6
C: Nutrition and Wellness Profile.....	7-8
D: Lifestyle Habits.....	9
E: Results You Wish to Achieve	10

Trademark of The Edge Fitness Business Consulting Ltd.
Copyright 2004 The Edge Fitness Business Consulting Ltd.
All Right Reserved. No part of this publication may be reproduced,
Stored in a retrieval system, or transmitted, in any form or by any means,
Electronic, mechanical, photocopying, recording, or otherwise,
Without the prior written permission of the publisher.

Welcome to Sports and Fitness EDGE, Chittenden County’s most
established fitness and wellness centers!

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, in order for us to provide you with an efficient, informative and accurate experience.

Step 1. At the time of your registration at Sports and Fitness EDGE, your membership director will schedule an appointment for your initial consultation. At this point you will be presented with an appointment card, listing several pre-consultation instructions. Please follow these instructions closely in order to ensure accuracy. As well, you will be issued our ProFitness Program Booklet to take home with you.

Step 2. Prior to your initial appointment, please complete the health and fitness questionnaire sections A through E. If you have any questions while completing your booklet, do not hesitate to give us a call and ask for either your membership director or the personal training department. ***Please bring this completed booklet with you to your initial fitness consultation appointment.***

Step 3. On the day of your consultation, please arrive at the club 15-20 minutes prior to your scheduled appointment. Ensure that you arrive equipped with appropriate exercise attire / workout gear. You should then inform the front desk that you have an appointment for your initial consultation. ***Once again, please ensure that your PROFITNESS PROGRAM Booklet is completed prior to your arrival.***

Step 4. Once changed, you will return to the front desk area where you will be met and greeted by one of our qualified Fitness Consultants.

The consultation is scheduled for 1 hour and consists of: a review of your health and fitness questionnaire; a variety of assessments and measurements; an assessment on the workout floor to determine equipment knowledge; and a short demonstration of correct technique.

Step 5. Upon completion of the consultation (body composition, aerobic capacity, exercise technique and intensity), your consultation 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 or reminder cards in the mail, along with phone calls to remind you every three months to schedule a new appointment.

Once again, Congratulations! We look forward to assisting you in the successful attainment of your health and fitness goals.

PERSONAL INFORMATION

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 the 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 1-1 ½ hours for your visit.
- **Do not** have chocolate, soft drinks, coffee, tea, or cigarettes, for 8 hours prior to your consultation.
- **Do not** exercise for 12 hours before your appointment.
- **Do not** schedule any important appointments immediately following your consultation so that you will be relaxed while you are with us.

Preliminary and Follow-up Fitness Consultations

1. Initial Consultation: _____ Time: _____
2. 12- week Update: _____ Time: _____
3. 24- week Update: _____ Time: _____
4. 36- week Update: _____ Time: _____

A: Personal Fitness Profile / History

1. Are you currently exercising? YES NO

If yes, what type of exercise? _____

Frequency: _____

Duration: _____

How many times a week are you able to realistically train for 1 hour _____

2. What recreational activities do you participate in? _____

3. Are you content with your current physical state? YES NO

Reason: _____

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

Duration: _____

5. Have you ever utilized the services of a personal trainer? YES NO

If yes, how long? _____ If no, why not? _____

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

Explain: _____

7. What brought you to the decision to enroll with us?

B: Medical History

Past or Present, do any of the conditions relate to you?

Heart Disease

- High blood pressure Low blood pressure Angina Pectoris Myocardial Infarction
 Heart murmur Cardiac Arrhythmia Tachycardia Rheumatic Fever

Cardiovascular Disease

- Arteriosclerosis Aneurysm Stroke Cholesterol Varicose Veins

Respiratory Disease

- Asthma Emphysema

Muscular-Skeletal Disorder

- Osteoarthritis Osteoporosis Rheumatoid Arthritis Tendonitis/Bursitis
 Whiplash Fibromyalgia Herniated Disc

Neurological Disorder

- Epilepsy Sciatica Insomnia Impingement Syndrome

Endocrine Disorder

- Diabetes Hyperthyroidism Hypothyroidism

Miscellaneous

- Hernia Anemia Ulcers Allergies Chronic Fatigue Syndrome
 Tumor/ Cyst Auto Immune Disorder Other _____

If one or more of the above conditions relate to you, please provide a brief detail (i.e. surgery/doctor's recommendation)

1. Have you ever been treated by: Chiropractor Physical Therapist
 When? _____ Why? _____

2. Are you accustomed to vigorous exercise? YES NO

3. 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 Movement

4. Can above pain or discomfort be described as a: Dull Ache Sharp Stab

Numbness or Tingling Other _____

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

6. Do you experience pain in these following areas?

If yes, please check the box that best describes the severity of pain you feel

	YES	NO	Extreme	Moderate	Mild	Left	Right
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C: Nutrition and Wellness Profile

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 need to focus on most.

Nutritional Profile	Always	Sometimes	Never
1. Do you consistently eat 3-5 meals daily? (including snacks)	4	2	0
2. Do you eat breakfast daily?	4	2	0
3. Do you use vitamin or mineral supplements?	4	2	0
4. Do you eat 3-5 servings of vegetables a day?	4	2	0
5. Does your nutrition include 5-12 daily servings of grain products?	4	2	0
6. Do you consume 2-5 servings of fruit daily?	4	2	0
7. Does your diet include 2-3 servings of meat, Poultry, fish, tofu, beans, or 1-2 eggs	4	2	0
8. Do you use a protein supplement?	4	2	0
9. Do you select lean cuts of meat or meals low in saturated fats?	4	2	0
10. Do you eat 2-4 servings of dairy products daily?	4	2	0
11. Do you follow a Vegetarian Diet?	4	2	0
12. Do you limit your intake of foods high in salts and cholesterol?	4	2	0
13. Do you drink at least 8 glasses of water daily?	4	2	0
14. Do you feel tired after a large or heavy meal?	4	2	0
15. Do you spend money on gimmicks and fads to decrease weight or become fit?	4	2	0

Wellness Profile	Always	Sometimes	Never
1. Do you avoid caffeine intake (stimulants, coffee)?	4	2	0
2. Do you avoid smoking or using tobacco products?	4	2	0
3. Do you limit your consumption of alcohol to one Drink a day?	4	2	0
4. Do you perform at least 30 minutes of moderate physical activity daily?	4	2	0
5. When exercising, do you warm up, cool down, & perform stretches?	4	2	0
6. Do you engage in resistance training at least two times per week?	4	2	0
7. Do you get at least 7-8 hours of sleep nightly?	4	2	0
8. Do receive routine medical check ups & immunizations?	4	2	0
9. Are you happy with the way you look and feel	4	2	0
10. Do you experience neck, back or joint pain	4	2	0
11. Do you have a sedentary job or watch more than 3 hours of television daily?	4	2	0
12. Do you feel there is not enough time in the day to accomplish all the tasks that you set for yourself?	4	2	0
13. When in a rush, do you have fast food or take-out-meals?	4	2	0
14. Do you eat or drink to the point of discomfort?	4	2	0
15. When feeling depressed, down or bored, do you find yourself eating, shopping, or gambling to relieve stress?	4	2	0

Wellness Profile Total:

Combined Total: /120

D: Lifestyle Habits

1. Occupation _____
Description of work performed _____

2. Hours worked per week _____ Number of hours worked per week _____
Do you work a set schedule?
Do you find your occupation to be stressful? _____
If YES, then why? _____

3. What do you do to relieve stress? _____

4. Have you ever smoked? YES NO
If YES, for how long? _____ Amount per day? _____

5. Do you presently smoke? YES NO
If YES, how much do you spend on cigarettes a week? \$ _____
If NO, then when did you quit? _____

6. Do you drink alcohol? YES NO
If YES, then how many drinks do you consume each week? _____

7. Do you drink coffee/ tea? YES NO

8. Which best describes your sleeping patterns? Good Average Poor
How many hours a night do you sleep on average? _____

9. Energy levels in the
Morning High Medium Low
Afternoon High Medium Low
Night High Medium Low

10. Do you possess background knowledge in the following categories:
 Nutrition Competitive Running Bodybuilding
 Weight Training Principles Cardiovascular Conditioning

E: Results You Wish To Achieve

- Weight Loss Aerobic Capacity Muscle Toning Body Building
- Intensity Training Flexibility Sport Specific Conditioning
- Stress Management Knowledge/ Education Nutrition Wellness Counseling
- Other _____

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

In your first year:

Beyond your first year:

Rate the importance of achieving your goals in relation to the other priorities in your life:

Lowest 1 2 3 4 5 Highest

How committed are you to achieving your goals?

Lowest 1 2 3 4 5 Highest

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 stated health and fitness goals.