HartHouse

PERSONAL FITNESS SERVICES

The following information will assist you in booking an Individual Consultation or Personal Training.

How do I book an Individual Consultation or Personal Training?

Please complete the attached forms and ensure that all questions are answered.

What do I do with the forms?

Present your completed forms to staff at The HUB.
Payment in the form of cash, cheque, credit card or debit card will be accepted.
For group personal fitness: each participant must complete these forms.

General Information

Each session will begin with an initial consultation of your needs, interests and goals. Each Personal Training session or consultation will be 55 minutes in length.

What do I wear?

Please be changed and ready to participate wearing shorts and a T-shirt, or workout attire, and comfortable training shoes for your scheduled appointment.

Where do I meet my Personal Trainer / Appraiser / Consultant?

On your initial visit, meet at the bench across from the Athletics Reception Desk.

What is the cancellation policy?

If it is necessary to change your appointment, please contact The HUB at 416.978.2452 at least 24 hours before your scheduled appointment. If you have a Personal Trainer please contact the Trainer directly. If cancellation takes place within 24 hours or you do not show up for the appointment, you will be charged the full rate for the missed appointment.

Please contact The HUB at 416.978.2452 if you have additional questions.

HartHouse

LIFESTYLE QUESTIONNAIRE

For Office Use Only:

With: ____

Date: ___________________ Time: ________________________

Staff Please Circle One:

Individual Consultation *Personal Training* *Group Package*

Last Name: _________________________________ First Name: _____________________

(Please Print)

Address: ____

Street *City* *Postal Code*

Telephone: Res: __________________ Bus: ___________________ Email: ____________________________

DOB: ____________________ Sex: ___________ Height: __________ Weight: ____________

(Day/Month/Year)

In case of emergency, please contact: ____

Phone # __________________________ Relationship: ____

Family Doctor: ____

Name *Telephone*

____

Address

Have you visited your physician in the last year? ☐ Yes ☐ No

Has your doctor restricted you from any physical activity? ☐ Yes ☐ No

If yes, specify: ____

Occupation: ____

With respect to physical activity how would you classify your work?

Sedentary ☐ Light ☐ Reasonably Active ☐ Very Active ☐

How would you describe your present level of fitness?

Excellent ☐ Good ☐ Fair ☐ Poor ☐

How often do you partake in physical activity?

5 - 7 times/week ☐ 3 - 4 times/week ☐ 1 - 2 times/week ☐

Monthly ☐ Occasionally ☐ Never ☐

What exercises (activities or sports) are you doing now?

Activities	Times/Week
______________________________	__________
______________________________	__________

(Please turn over ☐)

What activities would you prefer to avoid? ____

Exercise Objectives:

Relax, have fun	☐	Lose Weight	☐
Gain weight	☐	Improve general fitness	☐
Reduce tension	☐	Strengthen muscles	☐
Increase flexibility	☐	Increase cardiovascular endurance	☐
Tone muscles	☐	Improve posture	☐

Do you eat three meals a day? Yes ☐ No ☐ Usually ☐
Do you skip breakfast? Yes ☐ No ☐ Usually ☐
Do you salt your foods? Yes ☐ No ☐ Usually ☐
Are you presently on a diet? Yes ☐ No ☐ Usually ☐
If so, why? ____

Do you drink alcohol? Never ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Daily ☐
Do you drink coffee, tea or cola? Yes ☐ No ☐ Usually ☐
If so, how much? Coffee ____/day Tea ___/day Cola ___/day
Do you smoke? Never ☐ ___ /day

How would you describe your present state of health?
Excellent ☐ Good ☐ Fair ☐ Poor ☐

Are you presently taking any prescription drugs? Yes ☐ No ☐

If so, please specify: Name: _____________________ Dosage: __________________________

Side effects (if any): _____________________________________

Do you experience any of the following?

Joint Pain	Yes	☐	No	☐	Tendon pain	Yes	☐	No	☐
Muscle pain	Yes	☐	No	☐	Abdominal pain	Yes	☐	No	☐
Knee pain	Yes	☐	No	☐	Lower back pain	Yes	☐	No	☐
Neck pain	Yes	☐	No	☐	Shoulder pain	Yes	☐	No	☐
Shortness of breath	Yes	☐	No	☐	Asthma	Yes	☐	No	☐
Diabetes	Yes	☐	No	☐	High Blood Pressure	Yes	☐	No	☐

Frequent headaches requiring treatment Yes ☐ No ☐

Other difficulties (please specify) ____

If you answered yes to any of the above, please specify:
____

Are you undergoing treatment from any of the following:
Physiotherapy ☐ Chiropractor ☐ Massage Therapist ☐

If so, please indicate your injury: ________________________________. You may be required to obtain medical authorization to proceed.

Have you had major surgery in the last 10 years? Yes ☐ No ☐

If yes, please specify: ____