



NEEDS ANALYSIS

Name _____ Date _____
 Address _____ Zip _____
 Phone (H or C) _____ (W) _____ DOB ____/____/____ WT _____ HT _____
 E-mail Address _____

What is the best way to reach you?
 Circle one: Home Phone - Cell phone - E-mail - Cell Phone text message

PERSONAL BACKGROUND HISTORY

Are you presently exercising? ____ YES ____ NO How long have you been exercising regularly? _____
 Type of Exercise _____ Frequency _____ Duration _____
 Have you ever exercised in a fitness club before? ____ YES ____ NO
 Are you familiar with the weight training machines and cardio equipment ? ____ YES ____ NO
 Have you ever utilized the service of a Personal Trainer? ____ YES ____ NO How Long? _____

MEDICAL HISTORY

Past or Present: Do any of the following conditions relate to you?

- | | | | | |
|---|--|--|---|---|
| Heart Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Coronary Bypass
<input type="checkbox"/> Angina Pectoris
<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Cardiac Arrhythmia
<input type="checkbox"/> Tachycardia
<input type="checkbox"/> Rheumatic Fever | Cardiovascular Disease
<input type="checkbox"/> Atherosclerosis
<input type="checkbox"/> Stroke
<input type="checkbox"/> Aneurysm
<input type="checkbox"/> Cholesterol
<input type="checkbox"/> Varicose Veins
Respiratory Disease
<input type="checkbox"/> Asthma
<input type="checkbox"/> Emphysema
Musculo-Skeletal | Disorder
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Tendonitis/Bursitis
<input type="checkbox"/> Whiplash
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Herniated Disc
<input type="checkbox"/> Neurological Disorder
<input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sciatica
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Impingement Syn.
Endocrine Disorder
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Hypothyroidism
Miscellaneous
<input type="checkbox"/> Hernia
<input type="checkbox"/> Anemia
<input type="checkbox"/> Ulcers | <input type="checkbox"/> Allergies
<input type="checkbox"/> Chronic Fatigue Syn.
<input type="checkbox"/> Tumor/Cyst
<input type="checkbox"/> Auto Immune Dis.
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Other _____ |
|---|--|--|---|---|

If one or more of the above conditions relate to you please provide a brief detail:

Are you pregnant? _____ If so, indicate month of pregnancy _____
 Have you had any surgeries? _____
 If so, when and what was it for? _____
 When was your last physical examination? _____

Have you been given any exercise limitations by your doctor that we need to be aware of for Fitness Assessment purposes?

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

Do you experience the following symptoms prior, during or after physical activity?

Muscle Cramps Dizziness Neck or Back Pain Coughing/Nausea Crepitus
 Shortness of Breath Chest Pain Headaches/Migraines Grinding Joints- Irregular Bow Movements
 Swelling of joints

Can the above pain or discomfort be described as a Dull Ache Sharp Stab Numbness or Tingling Other _____
Is there any other physical reason not mentioned why you should not follow an exercise program? YES NO
If yes please specify _____

Do you have any pain in the following areas? *If yes, please mark the box that best describes the severity of pain you feel.*

	Yes	NO	Extreme	Moderate	Mild	Left	Right
Toes	_____	_____	_____	_____	_____	_____	_____
Forefoot	_____	_____	_____	_____	_____	_____	_____
Arch	_____	_____	_____	_____	_____	_____	_____
Heel	_____	_____	_____	_____	_____	_____	_____
Ankle	_____	_____	_____	_____	_____	_____	_____
Leg	_____	_____	_____	_____	_____	_____	_____
Knee	_____	_____	_____	_____	_____	_____	_____
Hip	_____	_____	_____	_____	_____	_____	_____
Low Back	_____	_____	_____	_____	_____	_____	_____
Neck	_____	_____	_____	_____	_____	_____	_____
Shoulder	_____	_____	_____	_____	_____	_____	_____
Elbow	_____	_____	_____	_____	_____	_____	_____
Wrist	_____	_____	_____	_____	_____	_____	_____

LIFESTYLE HABITS – BEHAVIOR

Occupation _____ Does it require extended periods of sitting? YES NO
Does it require repetitive movement? YES NO If yes, which ones? _____
Does it require you to wear shoes with a heel? YES NO
Does it cause you anxiety (mental stress)? YES NO
What do you do to relieve daily stress? _____
Do you partake in any recreational/leisure activity/hobbies (golf, tennis, skiing etc)? YES NO
If yes, please explain _____
Do you presently smoke? YES NO
How do you consider your sleep pattern? Good Average Poor How many hours do you sleep per night? ____
Energy levels in the..... Morning High Medium Low
Afternoon High Medium Low
Night High Medium Low

NUTRITION QUESTIONNAIRE

Nutrition experts agree that about 80% of the fitness puzzle is represented by nutrition.

1. Do you regularly & consistently eat 5-6 meals daily (including snacks?) Y N

Describe your typical day:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

How many 8oz glasses of water do you drink daily? _____

How many sodas weekly? _____

How much coffee daily? _____

How many alcoholic beverages weekly? _____

14. What do you find most challenging about managing your nutrition? (Healthy eating choices)

Lack of knowledge

Time constraints

Other (specify) _____

FITNESS/HEALTH GOALS

1. In a few words can you describe your fitness/health goals?

2. How many days a week can you commit to exercising in the club _____ Outside the club (jogging, walking etc) _____

3. Which time of the day would best fit your needs? _____

4. Which cardiovascular machines do you like? Treadmill Elliptical Bike ArcTrainer Stairmaster

Important: If you answered YES to or checked any of the questions in page 1 and 2, contact your physician as soon as possible.

Your physician's Name: _____ Phone Number: _____

Address: _____

I certify to the best of my knowledge the above information is correct and complete. I also understand that, Lara Locatello and Fit Together LLC. assume no responsibility for any illness, accident or injury I may incur from the use of the program, services or facilities. All individuals should consult with a physician before entering into any exercise program.

Client Printed Name _____

Client Signature _____



PERSONAL TRAINING ETIQUETTE/CANCELLATION/EXPIRATION POLICIES

- Clients must call 24 hours in advance to cancel a scheduled appointment with the trainer. Less than 24 hour notification or “no show” appointments will be deducted from the client’s account as a completed session. No refunds will be offered. Appointments cancelled by the trainer will not be charged and will be rescheduled promptly (no refund available).
- If the client is going to be late for an appointment, she/he should call ahead. The trainer will wait a maximum of 10 minutes for a client to arrive. When the client arrives late, he will have the time remaining in his originally scheduled session only.
- Payment for services is due in full before the services are performed.
- A \$25.00 fee will be charged for any returned checks. Training sessions will be suspended until cash payment is presented for past unpaid sessions. Future payments will be made on a cash-only basis.
- Any unused training sessions not used within Fit Together Expiration Guidelines (listed below) will be forfeited. No refunds are available for unused sessions.
- If the client cancels their personal training services, no refund for unused services will be issued. If the trainer cancels the personal training services, the trainer will refund to the client any payment for unused services.
- If the client misses a Buddy appointment, the training session will not be refunded and no-make up will be offered.
- One make-up session will be offered per month to clients who meet at least twice per week for group training.

Personal Training Session Expiration Guide	
# of Sessions	Expiration Date
8 or less	4-5 weeks
9 to 16	8-9 weeks
17-24	12-13 weeks

Client Printed Name _____

Client Signature _____

Date _____ / _____ / _____
 Mo. Day Yr.



PHOTOGRAPH and TESTIMONIAL
CONSENT AND RELEASE

FOR VALUABLE CONSIDERATION, the undersigned does hereby grant their consent and permission to allow Fit Together, LLC, a New Mexico limited liability company (Fit Together) to use certain photographs and testimonials of the undersigned, and/or **their children** in connection with the advertising of Fit Together's business activities, including, but not limited to, being displayed and shown on Fit Together's online website, and/or marketing and promotional materials, and does further release Fit Together and Lara Locatello from and against any claims or demands in connection with such usage (Consent and Release). This Consent and Release shall be in effect for a period of three (3) years from and after the date of its execution by the undersigned, and may include, but not be limited to the use of "before" and "after" pictures of the undersigned.

Client Printed Name _____

Client Signature _____

Date ____/____/____
Mo. Day Yr.