Nutrition Counselling and Health Coach Request

Request for Nutrition Counseling/Health Coach

Name________________________________ **Cell Number**____________________________

Address______________________________ **City**____________________________________

Email________________________________ **Home Number**__________________________

Birthdate_____________________________

Emergency Contact:

Name_________________________________Cell Number_________________________________

(Name of trainer)

Days & Times of Week Preferred:____

Personal Information:

1. Height____________Weight______________Ideal Weight_________________
2. How long have you been at your current weight?_______________________
3. How often are you presently exercising?___________ days/week ___________minutes/day
4. How often do you want to exercise?________ days/week____________minutes/day
5. What are your goals (short term & long term)?
   1.____
   2.____
   3.____

6. Do you do cardiovascular training, i.e. treadmill, aerobic classes? Y N ________
________days/week type:____

7. Do you do strength training? Y N ______________days/week

8. If you selected NO, When was the last time you were exercising on a consistent basis?_______________

9. What type of exercising were you doing?____
____

10. How experienced are you with cardiovascular training? Basic Moderate Advanced
11. How experienced are you with strength training? Basic Moderate Advanced

12. Do you have any exercise limitations, i.e. back pain, shoulder surgery? Y N
If yes, please list:____
____

LIFECENTER HEALTH & FITNESS CLUB

13. Please describe a typical day's meals:

Breakfast:________________________________ Dinner:________________________________

________________________________ ________________________________

________________________________ ________________________________

Lunch:________________________________ Snacks:________________________________

________________________________ ________________________________

________________________________ ________________________________

14. Do you skip meals? Y N If Yes, which ones?________________________________

15. How much water do you drink in 1 day? ______________cups/day

16. Do you have any dietary restrictions? Y N

If YES, please list:________________________________

____

LIFECENTER Nutrition and Health Coach Client Guidelines

- Payments must be made 24 hours in advance of the session
- If a session needs to be cancelled by the Client, the Client must contact the Nutritionist or Health Coach either by **LIFE**CENTER Voicemail #_________________________or
  Trainer's personal phone # _______________________ or
  LIFECENTER Front Desk 630-540-4848 as soon as possible
- If cancellation notice is not given prior to 24 hours of scheduled appointment, the appointment will be charged the full cost of the training session
- If the Client is more than 15 minutes late, the session is considered missed and will be charged the full cost of the training session
- If the Client is running late, please contact the **LIFE**CENTER Front Desk 630-540-4848 and have the Nutritionist or Health Coach advised
- Sessions are scheduled for 30 or 60 minutes, if the Client is late for the scheduled appointment, it is not the Nutritionist's or Health Coach's obligation to continue training past the original ending time
- If the Client is forced to cancel due to an emergency, the charges will be waived for that training session
- If the Nutritionist or Health Coach is late for the scheduled appointment, it is the Nutritionist's or Health Coach's responsibility to make up that time. Please understand it may not be possible on that particular day

I have read and understand the terms of this contract. If for any reason the Client/Trainer relationship is not conducive to a productive personal training session, the Client/Trainer has the right to terminate this contract at anytime. Notice must be given to the Fitness Coordinator verbally or in writing immediately.

____ ____

Client Signature Date Trainer Signature Date

FOR OFFICE USE

	Date	Time of Call	Spoke With	Call Results
1.				
2.				
3.				

Notes:

Health History Questionnaire

www.lifecenterfitness.org

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise with LIFECENTER, please read the following questions carefully and answer each one honestly. All information will be kept confidential.

YES NO **Section I**

One or more "YES" needs

☐ ☐ 1. Do you have a heart condition?

☐ ☐ 2. Have you ever experienced a stroke?

☐ ☐ 3. Do you have epilepsy?

☐ ☐ 4. Are you pregnant?

☐ ☐ 5. Do you have diabetes?

☐ ☐ 6. Do you have emphysema?

☐ ☐ 7. Do you have chronic bronchitis?

☐ ☐ 8. Have you had a graded treadmill test/stress test prescribed by a doctor in the past 12 months?

☐ ☐ 9. In the past 12 months, has a physician ever told you or are you aware that you have high blood pressure?

YES **Section II**

Three or more "YES" needs medical

☐ ☐ 10. Do you feel pain in your chest when you engage in physical activity?

☐ ☐ 11. In the past month, have you had chest pain when you were not doing physical activity?

☐ ☐ 12. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?

☐ ☐ 13. Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?

☐ ☐ 14. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?

☐ ☐ 15. Has a physician ever told you or are you aware that you have high cholesterol level?

☐ ☐ 16. Do you currently smoke?

☐ ☐ 17. Are you a male over 44 years of age?

☐ ☐ 18. Are you a female over 54 years of age?

☐ ☐ 19. Are you currently exercising *LESS* than 1 hour per week? If you answe your activities.

____

☐ ☐ 20. Any other medical conditions? *(Surgical procedures, injuries, etc…)* If yes, please list below:

Medications

Section III

Do you take any of the following medications? *(Doctor Prescribed)*

For the *Heart* YES NO
If YES, what type?________________________

For *High Blood Pressure* YES NO
If YES, what type?________________________

For *High Cholesterol* YES NO
If YES, what is your
Total Blood Cholesterol?__________________

Are you currently taking any other medications?

Medication	Purpose
______________	______________________
______________	______________________
______________	______________________
______________	______________________

I understand that any exercise program I undertake may create physical stress and subsequent harmful effects. I agree that it is solely my responsibility and not the responsibility of **LIFE**CENTER to require me to consult with a physician prior to commencing any exercise program, to remain under medical supervision if that is indicated, and to seek medical assistance in the event of an injury. I recognize that the use of equipment entails some risk of accidental injury to myself and to others and I agree that I will use such equipment and facilities with due care. I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Name____ Date____________________________

Signature____________________________________

Staff Use

❑ Cleared to Exercise

❑ Not Cleared to Exercise
Needs *Medical Release*

[Section I] [Section II]