PEAK
Performance Therapy & Wellness

Certified Functional Manual Therapy

Personal Training Intake Form

Name: _____ Date: _____

Telephone: _____

Best email address: _____ Preferred method of communication____

Date of Birth: _____ Height: _____ Weight: _____

How often do you exercise? ☐ ☐ ☐ ☐
0 days 2-3 days 4-5 days >5 days

What type of exercise? _____

Have you worked with a personal trainer before? Yes ☐ No ☐

If yes, how long did you train with them? _____

Where? _____

Do you currently see a chiropractor or a physical therapist for an injury? Yes ☐ No ☐

If yes, for what injury? _____

Have you been recently hospitalized? Yes ☐ No ☐

If yes, explain: _____

Do you smoke? Yes ☐ No ☐ Do you drink? Yes ☐ No ☐

Do you have high blood pressure? Yes ☐ No ☐

High cholesterol? Yes ☐ No ☐

Have you had a heart attack? Yes ☐ No ☐

Other Past Medical History

_____

_____

_____

_____

Do you consent to photos being taken for social media/newsletter etc ? _____

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