Train With Jane Ltd.
Personal Information Form

Name: ______________________________ Today's Date: __________________________

Address: ____

City: ___________________________________ Province :_____________________________

Postal Code: ____

Home Phone :____

Cell: ____

Email Address: ____

Fax Number: ____

Date of Birth:____

Emergency Contact Name: ____________________________________

Emergency Contact Number: __________________________________

Height: ___________ Weight:__________ Gender:________ Age: ________

Weekly Exercise Information: Explain in detail what type of resistance exercises, cardiovascular or sports activities you perform on average during a 7-day period.

Exercise/Activity	Days/week	Duration

Lifestyle / Professional Activity: How would you rate the activity level of your profession, or what you do during the day (non-exercise related).

☐ Sedentary ☐ Moderately Active ☐ Active ☐ Very Active
☐ Smoker ☐ Non Smoker

What time do you normally wake up? ___________ Go to bed at night? ________________
If you smoke, how many per day? ________________________________
If you smoke, for how many years? _______________________________
If you drink alcoholic beverages, what and how many per day?
____

What are your goals?

☐ Weight Loss ☐ Maintain/Improve eating habits ☐ Gain Weight
What is your goal weight? ________

Protein Requirements: Which best describes you?

☐ Sedentary Adult ☐ Exercising adult ☐ Competitive athlete
☐ Growing teenage athlete ☐ adult building muscle ☐ athlete restricting calories

Body Type: Which of the following statements best describes you?

☐ I can eat practically anything I want and I don't gain weight. I find it very hard to gain weight
☐ I can lose or gain weight by adjusting my activity level and eating habits.
☐ I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

Health & Medical Conditions: Check any that apply to you

☐ Family history of heart disease	☐ Diabetes	☐ High or low blood sugar
☐ Asthma	☐ Stroke	☐ Emphysema
☐ High Cholesterol	☐ Cancer	☐ Epilepsy
☐ High Blood pressure	☐ Liver disease	☐ Pancreatic disease
☐ Kidney disease	☐ Anemia	☐ Lactation
☐ High Cholesterol	☐ Osteoporosis	☐ Back Pain
☐ Joint replacement or repair	☐ Pacemaker	☐ Joint, Tendon or muscle pain

Are you currently taking any medication that would affect the following?
Heart Rate – Y N Blood Sugar – Y N Balance – Y N Blood pressure – Y N

Are you pregnant? Y N ____mths **Nursing?** Y N _______________

Last yearly full physican (blood work, blood pressure, etc.)?
Approx Date/Year:______________

Any restrictions/conditions that you have been advised of that we should be aware of?

____

____

Please list any other conditions or recent surgeries that you feel we should know about in planning a fitness program for you.

____

____

____

Please list below everything you eat in one 24 hour period. Be sure to include snacks and beverages, including water. Also show approximate amounts.

Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____
Time: ________ Food/Beverage: ____

Make a list of your favorite foods.

____
____
____
____
____
____

Make a list of foods that you dislike or are allergic to.

____
____
____
____
____

Have you ever been placed in a nutritional program in the past? Y N
What were your results? ____
____

Have you ever had your body fat tested? Y N
If yes, how was it tested and when? ____________________________________

I, ______________________________ AGREE TO ALLOW ___________________________, WEIGHT MANAGEMENT CONSULTANT, TO DESIGN A WEIGHT MANAGEMENT PROGRAM FOR ME TO ENHANCE MY HEALTH & FITNESS GOALS. I WILL FOLLOW THAT PROGRAM TO THE BEST OF MY ABILITY AND I WILL NOT HOLD **Train with Jane Ltd.** OR ANY ONE RELTAED PERSONS OR PARTIES PERSONALLY LIABLE FOR ANY PROBLEMS, ILLNESS OR INJURIES THAT MIGHT OCCUR DUE TO A SUDDEN CHANGE IN MY EATING HABITS. I UNDERSTAND THAT **Train with Jane Ltd**. IS NOT A REGISTERED OR LISCENCED DIETITIAN, NOR A MEDICAL PRACTITIONER. THIS WEIGHT MANAGEMENT PROGRAM DOES NOT REPLACE THE EXPERT ADVICE OR MEDICAL TREATMENT OF MY OWN PRIVATE DOCTOR. I HAVE GIVEN **Train with Jane Ltd.** ALL NECESSARY INFORMATION ABOUT MYSELF TO PREVENT ANY POSSIBLE COMPLICATIONS

Signature: ____ Date: ____________________