

Have A Blast While Getting In Shape.



“Our class has it all. Get in shape and never have another boring workout. I’ve gotten certified in everything from kickboxing to yoga all to bring you a workout class that will never make you bored. I team up the exercise with a rock solid nutrition program and finally get you the results you need. **This will be the best exercise experience you have ever had.**”

- Jeremy Biernat, Personal Trainer and Instructor

The Class will be limited to 20 people no exceptions so get signed up early

Time:

9:00-10:00 am
Tuesday and Thursday
Starts May 1st.

Cost:

\$69 for 4-weeks (register before April 30th)
\$79 Late Registration on May 1st
Nutrition Program Included

Location:

Finger Lakes Ballet Academy
24 Coy Street
Canandaigua, NY 14424

Registration:

Pick up sign-up sheets at Finger Lakes Ballet Academy or go online.
www.talltrainer.com/FLBAclass. Fill them out and drop them off at the Academy or Mail them with your check made out to:

Tall Trainer Fitness Systems
68 Gorham Street
Canandaigua, NY 14424

You will need:

A stability ball (large exercise ball) the size will depend on your height. I can have one for you on the first day. Cost: \$22.95

If you have any questions:

Visit: www.talltrainer.com for more information
or call Jeremy – (585)261-0533

Let’s get ready to have some fun!!

www.talltrainer.com / (585)261-0533 / fitness@taltrainer.com
68 Gorham Street / Canandaigua, NY 14424

Health History Form



Date: ____/____/____

NAME: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: () _____ - _____ Work: () _____ - _____

Cell Phone: () _____ - _____ Occupation: _____

Birthday: ____/____/____ Age: _____

E-mail: _____

In case of Emergency Call: _____ Phone: () _____ - _____

Physician Name: _____ Phone: () _____ - _____

How would you rate your general health?

- Excellent Very good Good Fair Poor

My main reason for exercising is:

- Lose Body Fat Improve Health/Daily Activity Other
 Gain Muscle Enhance Sport Performance

Explain your Goals: _____

1.) Are you Currently taking any medication? Yes No

Type: _____	Reason: _____
Type: _____	Reason: _____
Type: _____	Reason: _____

2.) Do you have or have you ever had any of the following conditions?

<u>CONDITION</u>	<u>DESCRIPTION</u>
Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

3.) Have you ever been injured in any of the following areas?

BODY PART

DESCRIPTION

WHEN?

Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Shoulders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arms	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Back	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

4.) Are you currently under the care of a physician for any reason at all?

Yes No If yes, explain _____

5.) Do you smoke cigarettes? Yes No If yes, how much? _____

6.) Do you know of any physical condition that you have that could be aggravated by exercising or exerting yourself?

Yes No If yes, explain _____

7.) Are you taking any medication which could cause a reaction while exercising?

Yes No If yes, explain _____

8.) Does your doctor know that you are beginning a new exercise program? Yes No

9.) If your doctor knows that you are going to begin a new exercise program, does he/she object? Yes No why? _____

Signature: _____ Date: _____

Exercise History and Goals

How would you rate your general health?

Excellent Very good Good Fair Poor

My main reason for exercising is:

Lose Body Fat Improve Health/Daily Activity Other
 Gain Muscle Enhance Sport Performance

Explain: _____

Exercise Experience:

Sports
 High School/College Sports: _____
 Current Sports: _____
 Want to get back to a sport? _____

- Cardiovascular Exercise: (ex. Walking, biking, aerobics) _____
- Resistance Training: (weight lifting or strength training) _____
- Flexibility Training: (ex. Yoga or stretching) _____

Personal Preferences

Favorites

Movie: _____ Food: _____

Beverage: _____ Color: _____

Exercise/Activity: _____ Least Favorite Exercise: _____

Time of day: _____

When I have free time I like to: _____

Occupational Behaviors

Job Title: _____ Years at current job: _____

Hours/Week: _____ Hours/Day: _____

Describe the typical day: _____

After work I usually feel: _____

Diet and Nutrition:

Past Diets: _____

I eat out: (includes fast food)

Rarely Once a month Once a week 2-4 times per week

More than 4 times per week

I know exactly how many calories I am eating throughout the day. Yes No

I would rate my nutrition knowledge and compliance a _____ out of 10. (10 being the best)

Group Exercise:

My motivation for joining this class is: _____

My biggest challenge in exercise and nutrition is: _____

What I want the teacher to help me with: _____

My teacher really needs to know/understand that: _____

My goal at the end of 6 months is to... _____
