



Health Consultation Form

DATE: _____

“Helping People Rebuild From the Inside Out”

Name _____ **Email** _____

Address _____

Phone Number (Home) _____ **(Work)** _____ **Age:** _____ **Weight:** _____

Referred By _____

How often do you participate in physical activities? _____ **Height:** _____

What activities are you currently involved in? _____

What health and fitness benefits would you most like to accomplish?

- | | | |
|--|--|---|
| <input type="checkbox"/> Sport specific training | <input type="checkbox"/> Trim, firm and define | <input type="checkbox"/> Increase energy |
| <input type="checkbox"/> Gain weight | <input type="checkbox"/> Reduce health risks | <input type="checkbox"/> Overcome chronic health issues |
| <input type="checkbox"/> Lose weight | <input type="checkbox"/> Maintain shape | <input type="checkbox"/> Reduce tension and stress |
| <input type="checkbox"/> Increase flexibility | <input type="checkbox"/> Reduce pain | <input type="checkbox"/> Increase strength |
| <input type="checkbox"/> Gain muscle | | <input type="checkbox"/> Other _____ |

Do you suffer from any of the following in the present? Have you had any of these ailments in the past?

- | | | | | |
|--|--|---|---|------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Depression | <input type="checkbox"/> Digestive problems | |
| <input type="checkbox"/> Osteoporosis | (Asthma, sinus, etc) | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Weight problems | |
| | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Pain or stiffness in: | <input type="checkbox"/> Back | <input type="checkbox"/> Knees | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulders |

Other health issues not on the list _____

List in order of priority which health and fitness goals you would most like to achieve.

Rate their importance on a scale of 1 –10.

Goal 1 _____ **Rating** _____ **Time Frame** _____

Goal 2 _____ **Rating** _____ **Time Frame** _____

Goal 3 _____ **Rating** _____ **Time Frame** _____

What can Vital Health do to help you reach your goals?

- | | | |
|---|--|---|
| <input type="checkbox"/> Become healthier | <input type="checkbox"/> Motivation | <input type="checkbox"/> Advance plateaus |
| <input type="checkbox"/> Weight-loss | <input type="checkbox"/> Organize workouts | <input type="checkbox"/> Lifestyle modification |
| <input type="checkbox"/> Post-rehab | <input type="checkbox"/> Nutritional counselling | <input type="checkbox"/> Muscular development |
| <input type="checkbox"/> Other | _____ | |

What is your “WHY” for wanting to achieve these goals? _____

Who are the people in your life that will give you support in this healthy lifestyle change? _____

What additional support and motivation would you like to receive from me? _____

If you could be guaranteed to achieve these specific results, how many sessions could you commit to each week or every two weeks? _____