**CONSULTATION FORM**

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| CLIENT INFO: |
| NAME:  | **DATE OF BIRTH: AGE:** |
| GENDER: M / F | **HOME NUMBER:** |
| MOBILE NUMBER: | **EMAIL:** |
| ADDRESS: |

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| EMERGENCY CONTACT: |
| NAME:  | **RELATION:** |
| HOME NUMBER: | **MOBILE NUMBER:** |
| EMAIL: |
| ADDRESS: |

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| INJURIES & AILMENTS / MEDICAL HISTORY: |
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| MOVEMENT LIMITATIONS AND COMPENSATIONS: |
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| TRAINING AGE/EXPERIENCE: |
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| EXERCISES PREFERENCES: |
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| TRAINING AVAILABILITY/SCHEDULE: |
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| OVERARCHING GOAL: |
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| GOALS (SMART): |
| SHORT-TERM (1-4 WEEKS): |
| MEDIUM-TERM (1-6 MONTHS): |
| LONG-TERM (6+ MONTHS): |

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| BARRIERS: |
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| STRATEGIES TO OVERCOME BARRIERS & MAXIMIZE MOTIVATORS: |
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| EQUIPMENT AVAILABLE OUTSIDE OF GYM: |
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| ADDITIONALL INFO: |
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