Client Information Questionnaire

Please complete and return to your Personal Trainer. All information received on this form will be treated as strictly confidential. Please fill out the forms completely and accurately. This information is essential to helping your trainer develop a program that addresses your needs, goals, and is safe and effective.

Name:_____ Date of Birth____/____/____
Age:_____ M D Y
Address:_____ Street City
State Zip Code
Phone: _____(h) _____(Cell) Email
address: _____
Occupation: _____
Emergency Contact: _____ Relationship:
_____ Phone Number:_____
Physician's Name:_____ Physician's Phone:
_____ Physician's
Address:_____
Street City State Zip Code
Your personal trainer will send information and seek clearance and instruction regarding your physical exercise program to your physician unless you request otherwise. Please provide 24 hours notice if you need to cancel or reschedule your personal training appointment. If not provided,we will have to charge a missed appointment fee.

Type to enter text PAR-Q FORM Please mark YES or No to the following:

YES or NO

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? _____

Do you frequently have pains in your chest when you perform physical activity? _____

Have you had chest pain when you were not doing physical activity? _____

Do you lose your balance due to dizziness or do you ever lose consciousness? _____

Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)? _____
Are you pregnant now or have given birth within the last 6 months? _____
Have you had a recent surgery? _____
If you have marked YES to any of the above, please elaborate below:
_____

Do you take any medications, either prescription or nonprescription, on a regular basis? Yes/No What is the medication for?
_____

How does this medication affect your ability to exercise or achieve your fitness goals?
_____
_____

Lifestyle Related Questions:

1) Do you smoke? YES NO If yes, how many per day? _____
2) Do you drink alcohol? YES NO If yes, how many glasses per week? _____
3) How many hours do you regularly sleep at night? _____
4) Describe your job: Sedentary Active Physically Demanding?
5) Does your job require travel? YES NO
6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____
7) List your 3 biggest sources of stress: a. _____ b. _____ c. _____
8) Do you regularly utilize the services of a massage therapist? YES NO
9) Is anyone in your family overweight? Mother Father Sibling Grandparent
10) Were you overweight as a child? YES NO If yes, at what age(s)? _____

Fitness History:

1) When were you in the best shape of your life?
_____
2) Have you been exercising consistently for the past 3 months? YES NO
3) When did you first start thinking about getting in shape?
_____
4) What if anything stopped you in the past?
_____
5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)?_____

Nutrition Related Questions:

1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? _____
2) How many times a day do you usually eat (including snacks)?
_____
3) Do you skip meals? YES NO
4) Do you eat breakfast? YES NO
5) Do you eat late at night? Often Sometimes Rarely Never
6) What activities do you engage in while eating? (TV, reading etc)
_____
7) How many glasses of water do you consume daily? _____
8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when?_____
9) Do you know how many calories you eat per day? YES NO If yes, how many?_____
10) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N If yes, please list the supplements:
_____
11) At work or school, do you usually: Eat out Bring food
12) How many times per week do you eat out? _____
13) Do you do your own grocery shopping? YES NO
14) Do you do your own cooking? YES NO
15) Besides hunger, what other reason(s) do you eat? Circle the ones that apply: Boredom Social Stressed Tired Depressed Happy Nervous

16) Do you eat past the point of fullness?Circle the ones that apply: Often Sometimes Rarely Never
17) Do you eat foods high in fat and sugar?Circle the ones that apply: Often Sometimes Rarely Never
18) List 3 areas of your Nutrition you would like to improve:

a._____ b._____
c._____

19) Would you like nutritional education or assistance from a professional coach? YES NO

Exercise Related Questions: Skip to next section if you are presently inactive.

1) How often do you take part in physical exercise? 5-7x/week 3-4x/week 1-2x/week
2) If your participation is lower than you would like it to be, what are the reasons? Lack of Interest Illness/Injury Lack of Time
Other_____
3) For how long have you been consistently physically active?
_____
4) What activities are you presently involved in? Cardio &/or Sports Frequency/Week Average Length Easy/Mod/Hard
_____
_____
_____
_____ Is cardio conditioning an area that you would like us to help you with? YES NO Strength Training Frequency/ Week Average Length Easy/ Mod/Hard
_____
_____

List exercises:
_____
_____
_____

Would you like some assistance with your muscle conditioning program? YES NO Realistically, how often a week would you like to exercise? _____x/week

Based on your commitment, how often would you like to see a trainer to help you achieve your goals? 3x/week 2x/week 1x/week 1x/two weeks 1x/ month Other:_____
What are the best days during the week for you to commit to your exercise program? M T W T F S S

If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent, etc. MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY SUNDAY

Goal Setting:

1.How can we best help you? Please check that which applies. Lose Body Fat Develop Muscle Tone Rehabilitate an Injury Nutrition Education Start an Exercise Program Design a more advanced program Safety Sports Specific Training Increase Muscle Size Fun Motivation
Other_____
_____

2. How important is it for you to achieve these goals? Please circle one: Very Semi Not very

3. How long have you been thinking about achieving these goals?
_____
_____

4. How will you feel once you've achieved these goals? Be specific.
_____
_____
_____

5. Where do you rate health in your life? Please circle one Low priority Medium Priority High priority

6. What do you think is the most important thing your Personal Trainer can do to help you achieve your fitness goals?

_____

_____

_____

7. Outline what you feel are the obstacles or your potential actions, behaviors, or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise, etc.).

_____

8. Outline 3 methods that you plan to use to overcome these obstacles: a. _____ b. _____ c. _____