Client Information Questionnaire

Please complete and return this form to your trainer. All information will be kept confidential, which is essential for creating a safe and effective program tailored to your needs.

Personal Information:

- Name: _____
- Date of Birth: ____/____/____ (MM/DD/YYYY)
- Age: _____
- Address: _____
- Phone: _____ (Home) _____ (Cell)
- Email: _____
- Occupation: _____

Emergency Contact:

- Name: _____
- Relationship: _____
- Phone: _____

Physician's Information:

- Name: _____
- Phone: _____
- Address: _____

Your trainer may contact your physician regarding your exercise program unless you request otherwise. Please provide 24-hours notice for cancellations to avoid a missed appointment fee.

****PAR-Q FORM****
Mark YES or NO for the following:

1. Has your doctor ever said you have a heart condition? _____
2. Do you experience chest pain during physical activity? _____
3. Have you had chest pain when not active? _____
4. Do you experience dizziness or loss of consciousness? _____
5. Do you have any health problems affecting exercise? _____
6. Have you been pregnant or given birth in the last 6 months? _____
7. Have you had recent surgery? _____

If you answered YES to any questions, please provide details:
_____

Medications:
Do you take any regular medications? Yes / No
If yes, please specify:
_____
How does this medication affect your exercise?
_____

Lifestyle 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. Average hours of sleep per night: _____

4. Job Type: Sedentary / Active / Physically Demanding?

5. Does your job require travel? YES / NO

6. Stress level (1-10): _____

7. Main sources of stress:
   a. _____
   b. _____
   c. _____
8. Do you often see a massage therapist? YES / NO

9. Is anyone in your family overweight? YES / NO

10. Were you overweight as a child? YES / NO

Fitness History:

1.When were you in your best shape? _____

2. Have you exercised consistently for the past 3 months? YES / NO

3. When did you think about getting in shape? _____

4.What has stopped you in the past?
_____

Nutrition Questions:

1. Nutrition rating (1=very poor, 10=excellent): _____

2. Times you eat daily (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. Activities while eating (TV, reading, etc.): _____

7. Glasses of water consumed daily: _____

8. Do you experience energy drops during the day? YES / NO

9. Know your daily calorie intake. YES / NO

10. Take vitamins or supplements? YES / NO
If yes, please list: _____
11. Do you eat out at work or school? Eat out / Bring food

12. Times you eat out weekly: _____

13. Do your grocery shopping? YES / NO

14. Do your cooking? YES / NO

15. Reasons for eating besides hunger (circle): Boredom, Social, Stress, Tired, Happy, Nervous

16. Do you eat past fullness? (circle): Often, Sometimes, Rarely, Never

Thank you for completing this questionnaire! Your answers will help us design a personalized program for you.