CLIENT INFORMATION QUESTIONNAIRE

Please complete and return to your Personal Trainer or to the reception desk ASAP

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: _____D.O.B._____ Age_____
ADDRESS:_____City:_____ ZIP_____
HOME/CELL NUMBER: _____WORK #:_____
OCCUPATION: _____EMAIL: _____
EMERGENCY CONTACT: _____PHONE NUMBER: _____
PHYSICIAN'S NAME_____PHYSICIAN'S PHONE_____
(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.

PAR-Q FORM

Please mark YES or No to the following:	**YES**	**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 non-prescription, 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?

❍ Boredom ❍ Social ❍ Stressed ❍ Tired ❍ Depressed ❍ Happy ❍ Nervous

16) Do you eat past the point of fullness? ❍ Often ❍ Sometimes ❍ Rarely ❍ Never

17) Do you eat foods high in fat and sugar? ❍ 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_____

Developing your Fitness Program:

1. Please circle how/when you prefer to exercise:

a) LARGE GROUPS SMALL GROUPS ALONE COMBINATION

b) MORNING AFTERNOON EVENING

2. Realistically, how often a week would you like to exercise? _____x/week

Goal Setting:

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_____

MEDICAL HISTORY QUESTIONNAIRE

All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin our exercise program. Your answers will help us design a comprehensive program that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will/maybe be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards.

Name:_____
Date: _____