EVOLVED

Personal Training

INITIAL ASSESSMENT/QUESTIONNAIRE

Name_____ **Date**_____

Tell me more about yourself.

By learning more about your lifestyle and your habits, we can take better care of you and make sure coaching is a good fit for your goals and individual needs.

_____ _____

Date of Birth Gender

Staying in touch

Please print clearly.

_____ _____

EMAIL MOBILE PHONE

How do you prefer me to contact you?

- Email
- Phone
- Video Chat
- Text
- Other (please specify):

  _____

□ **Fitness Assessment**

What do you want?

In general, what are your goals? Check all that apply.

- Lose weight/fat
- Gain weight
- Maintain weight
- Add muscle
- Improve physical fitness
- Look better
- Feel better
- Have more energy and vitality
- Get control of eating habits
- Get stronger
- Physique competition/modeling
- Improve athletic performance
- Other, Please Specify:

  _____

Do you have any medical conditions? If so, please explain.

What medications are you taking, if any?

What do you expect?

What are your short and long-term fitness goals?

Are you prepared to do what is needed to work towards your fitness and nutrition goals?

Have you tried anything in the past to change your habits, your health, your eating, and/or your body?

If so, what?

Which of those things worked well for you? (Even if you might not be doing it right now.)

Which of those things didn't work well for you?

PHYSICAL ACTIVITY: (Please describe your current and/or past physical activity)

Activity	Type/Intensity	# Days Per Week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-Training (weightlifting, Pilates, etc.)			
Sports or Leisure/Other (describe)			

Does anything limit you from being physically active?

_____

_____

Indicate daily stressors and rate the level of stress from 1 (extremely low) to 10 (extremely high):

Work____ Family____ Social____ Financial____ Health____ Other____

What helps you to unwind? _____

WEIGHT HISTORY:

Would you like to be weighed today?

□ Yes □ No

Current Weight _____ Desired Weight _____

Have you had recent changes in your weight that you are concerned about?

□ Yes □ No

If yes, please explain: _____

Right now, how would you rank your overall eating/nutrition habits?

Horrible **1 2 3 4 5 6 7 8 9 10** AWESOME!!!

DIET HISTORY

Do you follow any special diet or have diet restrictions or limitations for any reason?

YES NO

If you follow a special diet/nutritional program, check the following that apply:

□ Low Fat	□ Vegetarian	□ Weight Loss
□ No Gluten	□ No Wheat	□ Low Sodium
□ No Diary	□ High Protein	□ Diabetic
□ Low Carb	□ Vegan	□ Other

Please list any food allergies, sensitives or intolerances:

_____
_____
_____

Which meals do you eat regularly?

□ Breakfast	□ Dinner
□ Lunch	□ Snacks (time_____)

Who prepares the majority of your meals? _____

Who shops for food? _____

Where do you shop for food? _____

If you do, how much time do you spend cooking/prepping meals each day? _____

What percentage of the foods you eat are…**whole_____% organic_____% convenience_____%**

What are your food and nutrition goals?

_____
_____
_____

The nutrition/eating habits that are most challenging for me:

_____
_____

The nutrition/eating habits that I most pleased with:

_____
_____

EATING STYLE

Based on how you eat on a regular basis, please check all that apply:

- □ Fast Eater
- □ Emotional Eater (stressed, bored, sad, etc.)
- □ Late night-eater
- □ Time constraints
- □ Dislike "healthy" food
- □ Travel frequently
- □ Do not plan meals
- □ Rely on convenience items
- □ Family member(s) have different tastes
- □ Love to eat
- □ Eat too much
- □ Eat because I have to
- □ Negative relationship with food
- □ Struggle with eating issues
- □ Confused about food/nutrition
- □ Frequently eat fast food
- □ Poor snack choices

Food Cravings

_____

Food Dislikes

_____

Right now, how much do the people and things around you support health, fitness, and/or behavior change?

NOT AT ALL **1 2 3 4 5 6 7 8 9 10** COMPLETELY

On a scale of 1-10, how would you rank your overall health right now?

WORST **1 2 3 4 5 6 7 8 9 10** AWESOME!!!

Why?

_____

_____

On average, how many hours per night do you sleep?

- 4 or fewer hours
- 5 hours
- 6 hours
- 7 hours
- 8 hours
- 9 hours
- 10 or more hours

DISCLAIMER

Please recognize that it is your responsibility to work directly with your health care provider before, during, and after seeking nutrition and/or fitness consultation.

Any information provided is not to be followed without prior approval of your doctor. If you choose to use this information without such approval, you agree to accept full responsibility for your decision.

Client Signature:

_____