eastlink

Client Information Questionnaire

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 and goals.

Name:

Email address:

Date of Birth: (M/D/Y)

Occupation:

Age:

Emergency Contact Name/ Number:

Address:

Phone (home):

Relationship:

Work (cell):

Physicians Name/ Number:

Lifestyle Related Questions:

1. Do you smoke? YES NO If yes, how much?
   _____
2. Do you drink alcohol? YES NO How much, how often?
   _____
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. One 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? Who?

_____

10. Were you overweight as a child? YES NO If yes, at what age?

_____

_____

11. Have you had surgery in the last two years?

_____

_____

12. Please list all of the medications that you are currently taking.

_____

_____

Fitness History

1. When were you in the best shape of your life?

   _____

2. What was your body weight 6 months ago? _____
   One year ago?_____
3. Have you been exercising consistently for the past three months? YES NO
4. When did you first start thinking about getting in shape?
5. What if anything stopped you in the past?
6. On a scale of 1-10, how would you rate your current 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?Sometimes_____ Often_____ 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
9. Do you know how many calories you eat per day? YES NO
10. Do you take supplements? YES NO
11. At work, or school do you usually EAT OUT BRING FOOD
12. How many times per week do you usually 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 reasons do you eat?
    Bordom____ Social____Stressed___Tired___Depressed___Happy____Nervous___
16. Do you eat past the point of fullness? Often_____ Sometimes_____ Never_____
17. Do you eat foods high in fat and sugar? Often_____Sometimes_____ Never_____
18. List three areas of your Nutrition that you would like to improve:
    a._____b._____c._____

Exercise Related Questions: **(Skip to the next session if you are presently inactive)**

1.) How often do you take part in physical exercise?
    5-7x/wk 3-4x/wk 1-2x/wk

2.) If your participation is lower than you would like it to be what are your reasons?
    Lack of interest illness/injury Lack of time
    Other:_____

3.) How long have you been consistently active for?

4.) What activities are you presently involved in?

Cardio and/or Sports: (frequency/ intensity/time)

_____

_____

Strength Training: (frequency/intensity/time)

_____

_____

Stretching: (frequency/length)

_____

_____

5.) Please circle all the activities that interest you:

Group Fitness Classes	Indoor Cycling	Snowshoeing	Basketball
Baseball	Kayaking	Soccer	Partner Training
Swimming	Boxing	Pilates	Tennis
Triathlon	One on One Training	X-Country skiing	Football
Racquetball	Volleyball	Golf	Rock Climbing
Walking	Running	Wallyball	White Water Rafting
Hiking	Skiing	Snowboarding	Yoga

Developing your Fitness Program:

1. Please circle how you prefer to exercise:

a.	Inside	Outside	Combination	
b.	Large Groups	Small Groups	Alone	Combination
c.	Morning	Afternoon	Evening	

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

3. Realistically, how much time would you like to spend during each exercise session?

½ Hour 1 Hour 1 ½ Hours 2 Hours

4. What are the best days during the week for you to commit to your exercise program?

M T W T F S S

Goal Setting:

1. What are your training goals? (circle all that apply)

Lose Body Fat
Develop Muscle Tone
Rehabilitate an Injury
Nutrition Education
Start an exercise program
Other: _____

Design a more advanced program
Sports Specific Training
Increase Muscle Size
Fun
Motivation

2. Where do you rate health in your life? Low Priority Medium High

3. How committed are you to achieving your fitness goals? Very Semi Not Very

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

5. Outline what you feel are the obstacles or your potential actions, behaviours 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 a priority over exercise etc.)_____
_____
_____
_____
_____
_____

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