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Three-Day Dietary Record

Name	Date

It is important that this record be both accurate and representative of your normal dietary intake. Consequently, it is essential that you do not alter your normal eating habits in any way and that you record as precisely as possible every single item that you consume (this includes water, vitamins, condiments, margarine, etc). To do so, you must follow a few simple instructions (listed below). The purpose here is to quantify your normal intake so do not alter your eating habits in any way or the resulting analysis, although accurate, will be useless because it will not be representative of your typical diet. The procedure may seem somewhat cumbersome, but remember, it is only three days.

Instructions

1. Keep a pen and paper with you at all times to record your intake including food item, quantity, and notes. This is imperative as snacks are typically consumed unpredictably and, as a result, it is impossible to record them accurately unless your recording forms are nearby.
2. Use a small food scale if you have one or use standard measuring devices (e.g., measuring cups, measuring spoons) to record the quantities consumed as accurately as possible. If you do not eat all of the item (for instance a portion of an apparently delicious hastily prepared casserole of leftovers that turned out to be not so delicious), re-measure what's left and record the difference.
3. Record combination foods separately (i.e., hot dog, bun, and condiments) and include brand names of food items (list contents of homemade items) whenever possible.
4. For packaged items, use labels to determine quantities.
5. Record three days that are representative of your normal intake. Therefore if your weekdays are different from your weekends, pick two weekdays and one weekend. Likewise, if your M, W, and F are different from your T and Th and all these days are different from your Sat and Sun, you should pick one day to represent each unique schedule.

Sample Dietary Record, Day 1

Food Item (include brand name)	**Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc)	**Notes** (include ingredients and amounts of homemade items)
Breakfast		
2 pieces toast	*2 pcs*	
Margarine	*1 t*	
Orange Juice	*6 oz*	
Lunch		
Small pizza	*400 g*	*pepperoni, mushroom, cheese*
Dinner		
Chicken	*6 oz*	
Baked Potato	*6 oz*	
Mixed Vegetables	*1 c*	*peas, carrots, corn*

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Three-Day Dietary Record

Name	Date

Dietary Record, Day 1

Food Item (include brand name)	**Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc)	**Notes** (include ingredients and amounts of homemade items)

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Three-Day Dietary Record

Name	Date

Dietary Record, Day 2

Food Item (include brand name)	**Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc)	**Notes** (include ingredients and amounts of homemade items)

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Three-Day Dietary Record

Name	Date

Dietary Record, Day 3

Food Item (include brand name)	**Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc)	**Notes** (include ingredients and amounts of homemade items)

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Comprehensive Client Information Sheet

Name	Date

Instructions
This is your comprehensive client information sheet. With this sheet, we will ask you to provide some relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual fitness program for you. **Please answer all questions** in the most accurate manner possible while being as concise as possible.

Disclaimer
Please recognize the fact that it is **your responsibility** to work directly with your physician before, during, and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

Basic Information

1) What is your gender?	2) What is your age?	3) What is your date of birth (month/day/year)?
4) What is your height?	5) What is your weight (measured as of this morning)?	

6) What is your body fat percentage (have this taken *before* submitting this sheet)?

7) Please provide the following skinfold measures (mm).				8) Please provide the following girth measurements (in or cm).			
Abs		Subscapular		Neck		Chest	
Triceps		Suprailiac		Shoulder		Biceps	
Chest		Thigh		Waist		Hips	
Mid-axillary				Thigh		Calf	

9) What are your specific goals (rank these goals according to importance with 1 being the most important and 8 being the least)?

Improved health	Improved endurance	Increased muscle mass	Fat loss
Increased strength	Sport specific*	Increased power	Weight gain

*Please provide the sport or athletic event you are training for:

10) Is there a specific timeline for achieving a specific goal?

11) Circle which of the two are of greater importance:

a. Immediate progress that's less easily maintained b. Maintainable progress that may not be as rapid

Please explain:

Exercise Information

12) Rate your ability in the following exercises (check the box that corresponds with your ability):

Exercises:	Advanced	Intermediate	Novice	Unfamiliar
Compound movements				
Barbell squats				
Barbell deadlift				
Barbell bench press				
Bent-over barbell row				
Barbell Shoulder Press				
Pull-up				
Barbell hack squat				
Olympic movements				
Snatch				
Clean				

13) Are you currently exercising regularly (at least 3x per week)? circle one

YES If you answered YES, continue on to question 14.
NO If you answer NO, continue on to question 18.

14) How long have you been consistently doing so without a break?

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Comprehensive Client Information Sheet

Name

15) On the following chart, fill in which type of exercise you normally perform each day: resistance training (RT); interval cardio bouts (ICB); low-intensity cardio bouts (LICB); sport-specific work (SSW)

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Type of Exercise							

16) On the following chart, fill in your approximate workout duration for each day (in minutes).

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Duration							

17) Please submit your current exercise regimen along with this form (type it up or write it out for us). Please skip to question 19.

18) If you are not currently exercising regularly, have you ever been on a consistent exercise plan (at least 3x per week)? circle one

YES If you answered YES, how long ago was it, and how long did it last? _____
NO

Lifestyle Information

19) What do you do for a living?

20) What is the activity level at your job? None Moderate High

21) Does your job entail shift work? Y N

22) If you follow a more regular schedule, when do you work? Days Afternoons Nights

23) How often do you travel? Rarely Few times per year Few times per month Weekly

24) Please list the physical activities that you participate in outside of the gym and outside of work.

25) If you have any diagnosed health problems, list the condition(s).

26) If you are on any medications, please list them.

27) What additional therapies or interventions are being undertaken for the given health problem(s)?

28) If you have any injuries, please list them.

29) What additional therapies or interventions are being undertaken for the given injury(s)?

30) Please fill out the following timetable with your most normal daily schedule listing the time you wake up, work and have breaks, work out, and go to sleep.

A.M.				P.M.			
12:00 – 12:30		6:00 – 6:30		12:00 – 12:30		6:00 – 6:30	
12:30 – 1:00		6:30 – 7:00		12:30 – 1:00		6:30 – 7:00	
1:00 – 1:30		7:00 – 7:30		1:00 – 1:30		7:00 – 7:30	
1:30 – 2:00		7:30 – 8:30		1:30 – 2:00		7:30 – 8:30	
2:00 – 2:30		8:00 – 8:30		2:00 – 2:30		8:00 – 8:30	
2:30 – 3:00		8:30 – 9:00		2:30 – 3:00		8:30 – 9:00	
3:00 – 3:30		9:00 – 9:30		3:00 – 3:30		9:00 – 9:30	
3:30 – 4:00		9:30 – 10:00		3:30 – 4:00		9:30 – 10:00	
4:00 – 4:30		10:00 – 10:30		4:00 – 4:30		10:00 – 10:30	
4:30 – 5:00		10:30 – 11:00		4:30 – 5:00		10:30 – 11:00	
5:00 – 5:30		11:00 – 11:30		5:00 – 5:30		11:00 – 11:30	
5:30 – 6:00		11:30 – 12:00		5:30 – 6:00		11:30 – 12:00	

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Comprehensive Client Information Sheet

Name

Lifestyle Information (continued)

31) Exactly how much money do you spend on groceries per month (provide amounts from your last two grocery bills)?

32) How often do you grocery shop (number per week)?

33) How many meals do you eat in restaurants or fast food places per week?

34) Exactly how much money do you spend on supplements per month?

35) If you have any know food allergies, please list them below.

36) Are there any other foods to which you're particularly sensitive (i.e., which cause excessive gas, bloating, stuffiness, or congestion)?

37) If you're currently using any nutritional supplements, please list them (as well as the doses you're taking) below.

38) Please provide a Three-Day Dietary Record (attached). Be sure that these records are representative of the last few months of your dietary intake. In other words, if you just decided to get in shape two weeks ago and changed your diet dramatically, you should give us an indication of how you had been eating habitually prior to the recent change.

39) How long have you been eating in the manner recorded on your dietary record?
(If your answer is less than one month, please fill out your record according to your prior intake before this recent month.)

Miscellaneous Information

40) If there is any other information you think relevant to your program design, please share it with us below.

41) Please share your most frequent health, nutrition, or physique complaints and/or dissatisfaction with us.

You have now completed our client information sheet. Please bring this, along with your current workout schedule (if applicable) and Three-Day Dietary Record, to your first appointment.

Name of Company

Confidentiality Agreement

Please Read The Below Statement And Sign Where Indicated.

I, _____ understand that the information collected by Name of Business _____ will be used for fitness evaluation purposes and for the design, implementation, progression, and maintenance of an individualized fitness program only. I further understand that all such information is confidential and will not be shared with anyone without my prior written authorization, except in the case of a medical emergency or to the minimum extent necessary to achieve a safe and effective fitness program.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

Please note: possession of this form does not indicate certification status with the ISSA. To confirm active certification status, please call 1.800.892.4772 (1.805.745.8111 international). Information gathered from this form is not shared with ISSA. ISSA is not responsible or liable for the use or incorporation of the information contained in or collected from this form. Always consult your doctor concerning your health, diet, and physical activity.

Name of Business

Intake Questionnaire

Please Discuss The Following With All New Clients At Your First meeting

- **Why did you respond to our advertisement?**
  - a) What were you curious about?
  - b) What do you think we do?
  - c) Why would you be interested in that?
  - d) Ideally, what would you like us to do for you?
  - e) Why is that important?
  - f) How would it change your life?

- **Let me start out by giving you our definition of fitness.**
  - a) Experiencing abundant physical health.
  - b) Absence of pain, discomfort, illness, and disease.
  - c) Experiencing vitality and high energy, sufficient to enable one to do what one wants.
  - d) Looking attractive and fit, proud of one's appearance.
  - e) Capable of living a long, healthy life.
  - f) Able to participate in sports and active recreational activities.
  - g) Having a healthy emotional and mental outlook fostered by the foundation of feeling good.

  Do you agree with this definition?

  Is there anything you would add or delete?

- **What is the current state of your fitness?**
  - a) On a scale of 0-10 with 0 being barely alive and 10 being totally fit, how do you rate your fitness?
  - b) What illnesses or medical conditions do you have?
  - c) How is your energy level?
  - d) How would you rate the quality of your nutritional intake?
  - e) Do you feel refreshed and energized after sleep?
  - f) Is your sex life fulfilling? *(Don't ask this of clients of the opposite sex as it may be misconstrued.)*
  - g) What areas of your personal fitness would you like to improve?
  - h) What specific thing would you like to change? What else?

  What else?
  - i) If you could improve or change all these things, what would it mean to you?
  - j) How would it impact your feelings of self worth?
  - k) Do you think you deserve to be fulfilled in this area of your life?

- **What is your current fitness program?**
  - a) Exercises:
  - b) Nutrition and supplementation:
  - c) What do you know about how to improve your conditioning?

- **How well is your current fitness program working for you?**
  - a) Why isn't it working?
  - b) Are you willing to make some changes?
  - c) Do you care enough about your own well-being to make it a priority?

- **Aside from financial cost, is there anything that would stop you from embarking on a fitness program?**
  (Overcome all non-cost objections before proceeding.)

- **If you had everything you wanted in life except for good health, would that be satisfactory?**
  - a) How much do you pay for medical insurance?
  - b) How much do you pay for doctor bills?
  - c) Given the expensive cost of health care after one gets sick, doesn't it make sense to you to spend a little money to prevent health problems?
  - d) How much is your health worth?

- **If there were an affordable program that could give you everything you want in the way of health and fitness, would you do it?**

  When?_____ *(If they are not willing to act now, you should terminate interview at this point and ask them to come back when they are ready to make a change.)*

continued on back

Name of Business

Intake Questionnaire

Please Discuss The Following With All New Clients At Your First Meeting

Okay (Name), let me tell you a little about my experience and my personal philosophy of fitness. In working with clients, I like to focus on... (expand). I have lots of experience in... (expand on your areas of expertise). Most of my clients are able to achieve their goals because... (expand on your motivational skills).

Another reason for my high success rate is that I confine my practice to only those individuals who are really serious about improving their fitness. Are you? (Answer.)

Okay (Name), the next step is to set up an introductory session so that we can get a feel for how effectively we can work together. The session will last for forty-five minutes and the cost is just $.

At the end of the introductory session, we'll make a decision as to whether you should become my regular client or not. If the decision is "no" we'll just part as friends. If it's "yes," I'll ask you to commit to a series of sessions and we'll carefully define your goals and make sure that you reach them. Does that sound fair to you? (Yes.)

Good. What time of the day works best for you for the sample session… morning, afternoon, or evening? (Answer) Okay, I have two time slots open this week. (Tuesday at one o'clock or Wednesday at two o'clock) Which is better for you? (Choice.) Great, then I'll see you at (time). (While shaking hands enthusiastically...) It's been a pleasure meeting you.

Notes:

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	**YES**	**NO**
1) Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it ***does not limit your current ability*** to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Go to Page 4 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at **www.eparmedx.com** before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	**YES** ☐ **NO** ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	**YES** ☐ **NO** ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	**YES** ☐ **NO** ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	**YES** ☐ **NO** ☐

3. Do you have a Heart or Cardiovascular Condition? *This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm*

If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ☐ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	**YES** ☐ **NO** ☐
3c.	Do you have chronic heart failure?	**YES** ☐ **NO** ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	**YES** ☐ **NO** ☐

4. Do you have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES** ☐ **NO** ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	**YES** ☐ **NO** ☐

5. Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes*

If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ☐ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	**YES** ☐ **NO** ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	**YES** ☐ **NO** ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	**YES** ☐ **NO** ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	**YES** ☐ **NO** ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	**YES** ☐ **NO** ☐

PAR-Q+

6. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome*

If the above condition(s) is/are present, answer questions 6a-6b — If **NO** ☐ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d — If **NO** ☐ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c — If **NO** ☐ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c — If **NO** ☐ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c — If **NO** ☐ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

PAR-Q+

If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that the Trustee maintains the privacy of the information and does not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

www.eparmedx.com

Email: eparmedx@gmail.com

Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

OSHF Ontario Society for Health and Fitness

International Sports Sciences Association

Name of Business

Screening Questionnaire

Please Fill Out All Information Below

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	

Please Check The Box For The Appropriate Answer

Has your doctor ever said you have heart trouble?	❒ Yes	❒ No
Have you ever had angina pectoris, sharp pain, or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing stairs? *(Note: This does not include the normal out of breath feeling that results from normal activity)*	❒ Yes	❒ No
Do you experience any sharp pain or extreme tightness in your chest when you are hit with a cold blast of air?	❒ Yes	❒ No
Have you ever experienced rapid heart action or palpitations?	❒ Yes	❒ No
Have you ever had a real or suspected heart attack, coronary occlusion, myocardial infarction, coronary insufficiency, or thrombosis?	❒ Yes	❒ No
Have you ever had rheumatic fever?	❒ Yes	❒ No
Do you have diabetes, hypertension, or high blood pressure?	❒ Yes	❒ No
Does anyone in your family have diabetes, hypertension, or high blood pressure?	❒ Yes	❒ No
Has more than one blood relative (parent, sibling, first cousin) had a heart attack or coronary artery disease before the age of 60?	❒ Yes	❒ No
Have you ever taken medications or been on a special diet to lower your cholesterol?	❒ Yes	❒ No
Have you ever taken digitalis, quinine, or any other drug for your heart?	❒ Yes	❒ No
Have you ever taken nitroglycerine or any other tablets for chest pain—tablets you take by placing under the tongue?	❒ Yes	❒ No
Are you overweight?	❒ Yes	❒ No
Are you under a lot of stress?	❒ Yes	❒ No
Do you drink excessively?	❒ Yes	❒ No
Do you smoke cigarettes?	❒ Yes	❒ No
Do you have a physical condition, impairment or disability, including a joint or muscle problem, that should be considered before you undertake an exercise program?	❒ Yes	❒ No
Are you more than 65 years old?	❒ Yes	❒ No
Are you more than 35 years old?	❒ Yes	❒ No
Do you exercise fewer than three times per week?	❒ Yes	❒ No

International Sports Sciences Association

Name of Business

Client Dietary Worksheet

PLEASE FILL OUT ALL INFORMATION BELOW

Date:	Day:

Time	Food and Amount	Grams		
		Protein	Carbs	Fat
	TOTAL			
	GRAM GOAL			

Name of Business

Exercise History Questionnaire

Exercise History Information

Are you currently involved in a regular exercise program? ❒ Yes ❒ No

Do you regularly walk or run 1 or more miles continuously? ❒ Yes ❒ No

If yes, what is the average number of miles you cover in a workout? _____

What is your average time per mile? _____

Do you practice weightlifting or calisthenics? ❒ Yes ❒ No

Are you involved in an aerobic program? ❒ Yes ❒ No

If yes, what type(s)? _____

Do you frequently compete in competitive sports? ❒ Yes ❒ No

If yes which one(s)?

- ❒ Golf
- ❒ Bowling
- ❒ Tennis
- ❒ Handball
- ❒ Soccer
- ❒ Basketball
- ❒ Volleyball
- ❒ Football
- ❒ Baseball
- ❒ Track
- ❒ Other:_____
- ❒ Average number of times per week:_____

In which of the following high school or college athletics did you participate?

- ❒ None
- ❒ Football
- ❒ Basketball
- ❒ Baseball
- ❒ Soccer
- ❒ Other:_____
- ❒ Track
- ❒ Swimming
- ❒ Tennis
- ❒ Wrestling
- ❒ Golf

Do you frequently compete in competitive sports?

- ❒ Walking and/or Running
- ❒ Swimming
- ❒ Stationary Biking
- ❒ Jumping Rope
- ❒ Basketball
- ❒ Other:_____
- ❒ Bicycling (outdoors)
- ❒ Stationary Running
- ❒ Tennis
- ❒ Handball
- ❒ Squash

Comments:_____

_____

_____

_____

_____

_____

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS:_____
or GUARDIAN (for participants under the age of majority)

Name of Business

Informed Consent

Please Fill Out All Information Requested Below

I, (print name) _____ , give my consent to participate in the physical fitness evaluation program conducted by **Name of Business**.

BENEFITS

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

RISKS

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted below) that would increase my risk of illness and injury as a result of participation in a regular exercise program.

TESTING AND EVALUATION RESULTS

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of completing this health inventory, taking a step test or bicycle ergometer test for cardiovascular fitness, and being tested for muscular fitness and body composition.

I further understand that such screening is intended to provide **Name of Business** with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all test results. I may share the results with whomever I please, including my personal physician. By signing this consent form I understand that I am personally responsible for my actions during my tenure at **Name of Business** , and that I waive the responsibility of this center if I should incur any injury as a result of my negligence.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

Name of Business

Medical History Questionnaire

PLEASE FILL OUT ALL INFORMATION REQUESTED BELOW

Member's Name:			Date:		
Please indicate in the space provided if you have a history of the following:					
1.	Heart attack		YES		NO
2.	Bypass or cardiac surgery		YES		NO
3.	Chest discomfort with exertion		YES		NO
4.	High blood pressure		YES		NO
5.	Rapid or runaway heartbeat		YES		NO
6.	Skipped heartbeat		YES		NO
7.	Rheumatic fever		YES		NO
8.	Phlebitis or embolism		YES		NO
9.	Shortness of breath w/ or wo/exercise		YES		NO
10.	Fainting or light-headedness		YES		NO
11.	Pulmonary disease or disorder		YES		NO
12.	High blood fat (lipid) level		YES		NO
13.	Stroke		YES		NO
14.	Recent hospitalization for any cause		YES		NO
	List specifics:				
15.	Orthopedic problems (including arthritis)		YES		NO
	List specifics:				

FOR ANY OF THE CONDITIONS CHECKED ABOVE, PLEASE LIST THE DIAGNOSIS AND EXAMINING PHYSICIAN:

Please note: possession of this form does not indicate certification status with the ISSA. To confirm active certification status, please call 1.800.892.4772 (1.805.745.8111 international). Information gathered from this form is not shared with ISSA. ISSA is not responsible or liable for the use or incorporation of the information contained in or collected from this form. Always consult your doctor concerning your health, diet, and physical activity.

Name of Business

Health History Questionnaire

Answer Each Question By Printing The Necessary Information. Your Answers Are Confidential.

Name:	Date of Birth:	Age:
Address:		
City, State, Zip:		
Home Phone:	Work Phone:	
Employer:	Occupation:	
In case of emergency, please notify:		
Name:	Relationship:	
Address:		
City, State, Zip		
Home Phone:	Work Phone:	

Medical Information

Physician:	Phone:	
Are you under the care of a physician, chiropractor, or other health care professional for any reason? If yes, list reason:	❒ Yes	❒ No
Are you taking any medications? *(If yes, complete the following)* Type: Dosage/Frequency: Reason for Taking:	❒ Yes	❒ No
Please list any allergies:		
Has your doctor ever said your blood pressure was too high?	❒ Yes	❒ No
Has your doctor ever told you that you have a bone or joint problem that has been or could be made worse by exercise?	❒ Yes	❒ No
Are you over the age of 65?	❒ Yes	❒ No
Are you unaccustomed to vigorous exercise?	❒ Yes	❒ No

Health History Questionnaire

Medical Information, continued

Is there any reason not mentioned why you should not follow a regular exercise program? ❒ Yes ❒ No
If yes, please explain:

Have you recently experienced any chest pain associated with either exercise or stress? ❒ Yes ❒ No
If yes, please explain:

Smoking

Please check the box that describes your current habits:

- ❒ Non-user or former user; Date quit:_____
- ❒ Cigar and/or pipe
- ❒ 15 or less cigarettes per day
- ❒ 16 to 25 cigarettes per day
- ❒ 26 to 35 cigarettes per day
- ❒ More than 35 cigarettes per day

Family and Personal Medical History

If there is family history for any condition, please check the box to the left. If you are personally experiencing any of these conditions, fill the information in on the line to the right.

- ❒ Asthma:_____
- ❒ Respiratory/Pulmonary Conditions:_____
- ❒ Diabetes: Type I:_____ Type II:_____ How Long?_____
- ❒ Epilepsy: Petite Mal:_____ Grand Mal:_____ Other:_____
- ❒ Osteoporosis:_____

Lifestyle and Dietary Factors

Please fill in the information below:

- ❒ Occupational Stress Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Energy Level: ❒ Low / ❒ Medium / ❒ High
- ❒ Caffeine Intake/Daily:_____ ❒ Alcohol Intake/Weekly:_____
- ❒ Colds Per Year:_____ ❒ Anemia:_____
- ❒ Gastrointestinal Disorder:_____
- ❒ Hypoglycemia:_____
- ❒ Thyroid Disorder:_____
- ❒ Pre/Postnatal:_____

Cardiovascular

Please fill in the information below:

- ❒ High Blood Pressure:_____ ❒ Hypertension:_____
- ❒ High Cholesterol:_____
- ❒ Hyperlipidemia:_____
- ❒ Heart Disease:_____
- ❒ Heart Disease:_____
- ❒ Heart Attack:_____ ❒ Stroke:_____
- ❒ Angina:_____ ❒ Gout:_____

Health History Questionnaire

Family and Personal Medical History, continued

Musculoskeletal Information

Please describe any past or current musculoskeletal conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

- ❒ Head/Neck:_____
- ❒ Upper Back:_____
- ❒ Shoulder/Clavicle:_____
- ❒ Arm/Elbow:_____
- ❒ Wrist/Hand:_____
- ❒ Lower Back:_____
- ❒ Hip/Pelvis:_____
- ❒ Thigh/Knee:_____
- ❒ Arthritis:_____
- ❒ Hernia:_____
- ❒ Surgeries:_____
- ❒ Other:_____

Nutritional Information

Are you on any specific food/diet plan at this time? If yes, please list:	❒ Yes	❒ No
Do you take dietary supplements? If yes, please list:	❒ Yes	❒ No
Do you experience any frequent weight fluctuations?	❒ Yes	❒ No
Have you experienced a recent weight gain or loss? If yes, list change: Over how long?	❒ Yes	❒ No
How many beverages do you consume per day that contain caffeine?		
How would you describe your current nutritional habits?		
Other food/nutritional issues you want to include *(food allergies, mealtimes, etc.)*		

Health History Questionnaire

Work And Exercise Habits

Please check the box that best describes your work and exercise Habits.

- ❒ Intense occupational and recreational exertion
- ❒ Moderate occupational and recreational exertion
- ❒ Sedentary occupational and intense recreational exertion
- ❒ Sedentary occupational and moderate recreational exertion
- ❒ Sedentary occupational and light recreational exertion
- ❒ Complete lack of all exertion

To what degree do you perceive your environment as stressful?

Work: ❒ Minimal ❒ Moderate ❒ Average ❒ Extremely

Home: ❒ Minimal ❒ Moderate ❒ Average ❒ Extremely

Do you work more than 40 hours a week? ❒ Yes ❒ No

Please make any other comments you feel are pertinent to your exercise program.

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

Name of Business

Medical Release

Please complete the following information

It is my understanding that _____ will be participating in a fitness evaluation and exercise program. This patient is permitted to participate in the following activities. *(Please check all that apply.)*

1. Comprehensive physical fitness assessment including:
   - ❒ submaximal aerobic capacity test for cardiovascular endurance
   - ❒ resting heart rate, resting blood pressure
   - ❒ body composition analysis
   - ❒ flexibility
   - ❒ baseline upper and lower body strength measures
   - ❒ baseline upper and lower body endurance measures
   - ❒ other: _____
2. Exercise/rehabilitation program including:
   - ❒ resistance exercise program
   - ❒ cardiovascular exercise program
   - ❒ nutritional recommendations
   - ❒ other: _____

Please check the appropriate response:

- ❒ This patient may participate with no restrictions.
- ❒ This patient may participate with the following limitations:

- ❒ This patient may not participate. *(If checked, the individual will not be accepted.)*
- ❒ Other:

Diagnosis/Recommendations/Comments:

Signature

PHYSICIAN NAME *(please print)*

PHYSICIAN SIGNATURE DATE

PARTICIPANT NAME *(please print)*

PARTICIPANT SIGNATURE DATE

Additional Resources

Contents

For additional assistance please call our Technical Department to speak with an on-staff Master Trainer at 1.800.892.4772.

Letter Writing

Letters of Introduction

A professional letter written to a prospect may be one of the single most important marketing strategies you can develop. Even if prospects don't read flyers, or answer all of their phone messages immediately, most people read their mail every day. That letter may convince them to make that call that they have thought about, but have not acted on yet.

A sample letter would read something like this:

Dear (Name),

In response to your recent inquiry about personal training, I would like to tell you a bit about my professional qualifications.

I'm certified by The International Sports Sciences Association as a Certified Fitness Trainer. This certification is the most prestigious in the industry and it qualifies me to work with virtually any individual wishing to improve their fitness.

I've been a trainer since (Year) and have worked with more than (number) clients in my career. I have abundant in-depth experience with virtually every form of exercise but most of my clients say that my greatest asset is my ability to motivate and inspire people.

I invite you to call me at (phone number) any morning between 9 A.M. and 10 A.M. so we can discuss your fitness objectives and see if I may be of service to you.

Sincerely,

John Q. Trainer

Writing Referral Cards

Referral Cards

Many doctors and allied health practitioners like to do business (i.e.: patient referrals) through referral cards. These are printed pieces that give brief descriptions of the services that are going to take place. If these professionals are familiar with your work, and are willing to refer, then this card may be ideal for them to give to patients who may wish to work with you when they have completed their initial health care.

Trainer's Best Fitness Services
1101 South Broadway Avenue, Suite 200
Los Angeles, CA 90020
213-555-9890

Name of Patient:_____

Date:_____ Referring Physician:_____

Diagnosis: _____

_____

_____

Type of Service(s):

Exercise Training: _____

Stretching and Movement: _____

Aerobic/Cardiovascular Conditioning: _____

Sports Conditioning (list event): _____

Specific Recommendations: