

NAME: _____ Age _____
ADDRESS: _____ City: _____ ZIP _____
HOME/CELL NUMBER: _____ WORK #: _____
OCCUPATION: _____ EMAIL: _____
EMERGENCY CONTACT: _____ PHONE NUMBER: _____

Questionnaire

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 _____

3) For how long have you been consistently physically active? _____

4) What activities are you presently involved in?

Cardio &/or Sports	Frequency/Week	Average Length	Easy/Mod/Hard
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Is cardio conditioning an area that you would like us to help you with? YES NO

Strength Training	Frequency/Week	Average Length	Easy/Mod/Hard
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List exercises: _____

Would you like some assistance with your muscle conditioning program? YES NO

Stretching	Frequency/Week	Average Length
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Would you appreciate some help with a stretching program? YES NO

5) Please circle all the activities that interest you:

Group Fitness Classes
Private Personal Training
Partner Training
Boxing workouts
Indoor Cycling
Pilates/Yoga
Running Programs
Walking Programs

Snowshoeing
Cross Country Skiing
Hiking
Golf
Basketball
Baseball
Rockclimbing
Skiing/Snowboarding

Football
Soccer
Swimming
Tennis
Triathlon
Volleyball
Kayaking
White Water Rafting

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

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

4. Based on your commitment, how often would you like to see a trainer to help you achieve your goals?
3x/week 2x/week 1x/week 1x/two weeks 1x/month Other: _____

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

M T W T F S S

6. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent, etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

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 _____

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

S= Specific (Provide details, how long, how much etc.)

M= Measurable (How will you measure whether you've reached your goals)

A= Attainable (Be realistic, set smaller goals)

R = Rewards-Based (Attach a reward to each goal)

T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

a) _____

b) _____

c) _____

2. How important is it for you to achieve these goals? ☐ Very ☐ Semi ☐ Not very

3. How long have you been thinking about achieving these goals? _____

4. How will you feel once you've achieved these goals? Be specific.

5. Where do you rate health in your life? ☐ Low priority ☐ Medium Priority ☐ High priority

6. How committed are you to achieving your fitness goals? ☐ Very ☐ Semi ☐ Not very

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

8. Outline what you feel are the obstacles or your potential actions, behaviors, 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 to become a priority over exercise, etc.).

9. Outline 3 methods that you plan to use to overcome these obstacles:

a. _____ b. _____ c. _____

CLIENT

DATE

GUARDIAN'S SIGNATURE

Required for clients 17 years old and younger

DATE

FITNESS COACH

DATE