



Client Questionnaire

This information is essential to helping us develop a safe and effective program to address your needs, goals, and interests. All information on this form will be kept strictly confidential. Please fill out the forms as completely and as accurately as possible.

Date: _____

Name: _____ Birth Date: _____ (MM/DD/YYYY)

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Physician's Address: _____

Physiotherapist's Name: _____ Phone: _____

Does your physician know you are participating in this exercise program? Y [] N []

Other Comments: _____

Past Injuries: _____

Weight: _____ Height: _____

Blood Cholesterol Total: _____ HDL: _____ LDL: _____

Resting BP: _____ Resting HR: _____ Max HR: _____

Health and Lifestyle Information

The answers to these questions will give your trainer the information necessary to make valuable recommendations about various aspects of your daily routine to attain your goals (remember: all answers are strictly confidential and are used only to ensure that the best possible program is designed for you). Achieving your fitness goals requires discipline in your lifestyle as well as your exercise program, and your trainer will only make recommendations to benefit your overall health and help you reach your target.

1. Do you smoke? Y [] N [] If yes, how many per day? ____ For how many years? ____
2. Do you drink alcohol? Y [] N [] If yes, how many drinks per week? ____ For how many years? ____
3. How many hours do you regularly sleep at night? ____
4. Please rate you job (circle most appropriate):
Sedentary 0 1 2 3 4 5 6 7 8 9 10 Physically Demanding
5. How do you rate your general, daily stress level?
Very Low 0 1 2 3 4 5 6 7 8 9 10 Very High
6. List your 3 biggest sources of stress:
1 _____ 2 _____ 3 _____
7. What are some strategies you use to decrease these stresses? _____

8. How would you rate your overall level of happiness?
Very Low 0 1 2 3 4 5 6 7 8 9 10 Very High
9. What are the top 3 things that bring you happiness and make you feel good about yourself?
1 _____ 2 _____ 3 _____
10. Is anyone in your family obese? Mother [] Father [] Sibling [] Grandparent []
11. Were you overweight as a child? Y [] N [] If yes, at what age? ____
12. Do you have a family history of heart disease in any member of your immediate family prior to the age of 55? Y [] N []
If yes, who and at what age? _____
14. Are you pregnant, or have you given birth within the last 6 months? Y [] N []
15. Have you recently had surgery? Y [] N []
If yes, what for? _____

Nutrition Information

As professional trainers we often tell our clients that nutrition is probably 70-80% responsible for the results (or lack of results) that any individual experiences as a result of their fitness and wellness efforts. To be able to properly guide clients toward their goals, it is essential that we have an understanding of their dietary habits, both good and bad. We provide all clients with a simple eating plan that will ensure their diet is providing adequate nutrition for energy, recovery and optimal health.

1. How would you rate your nutrition?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

2. How many times/day do you usually eat (including snacks)? _____

3. Do you skip meals? Y [] N []

4. Do you eat breakfast? Y [] N []

5. Do you eat late at night? Sometimes [] Often [] Never []

6. How many liters of water do you consume daily (1 small glass = 0.25 liters)? _____

7. How many cups of coffee/tea do you drink per day? _____ With: Milk [] Cream [] Sugar []

8. Do you feel low-energy throughout the day? Y [] N [] If yes, when? _____

9. Do you know roughly how many calories you eat per day? Y [] N [] If yes, how many? _____

10. Are you currently taking a multivitamin or any other food supplements? Y [] N []

If yes, please list the supplements: _____

11. At work, do you: Eat Out [] _____ times/week Bring Food [] _____ times/week

12. What are your top 3 choices of food when you eat out at lunchtime?

1 _____ 2 _____ 3 _____

13. Besides hunger, what other reason(s) do you eat or snack?

Boredom [] Social [] Stress [] Tired [] Depressed [] Happy [] Nervous []

14. Do you eat past the point of fullness? Often [] Sometimes [] Never []

15. Do you eat at least 2 servings of quality protein per day? Y [] N []

16. Do you eat foods you know to be high in fat and sugar? Often [] Sometimes [] Never []

17. If possible, list 3 areas of your nutrition you would like to improve:

1 _____ 2 _____ 3 _____

Goal Setting

Proceeding along any journey without a clear plan of where one might end up is a recipe for inefficiency. Setting goals and formatting a realistic plan of achieving those goals is as important in fitness as it is in other aspects of life. After reviewing answers to the following questions, your personal trainer will be better prepared to develop exactly the right exercise and wellness program for your wants and needs. For successful goal setting, the goals must follow the "SMART" protocol: S=Specific M=Measurable A=Attainable R=Realistic T=Timely.

1. How would you rate your present fitness level?

Very Poor 0 1 2 3 4 5 6 7 8 9 10 Very Good

2. What areas are most important to you? Check all that apply.

Improving Health [] Increase Strength [] Increase Endurance [] Injury Rehabilitation []
Nutrition Education [] Improving Appearance [] Increase Flexibility [] Sport Specific Training []
Increase Energy [] Decrease Body Fat [] Increase Muscle Size [] Fun []

3. In order of priority, and in detail, list the fitness goals you would like to achieve in the next 2-6 months?

1 _____

2 _____

3 _____

4. What is your major fitness goal that you would like to achieve in 12 months? _____

5. What do you think is the most important thing your personal trainer can do to help you achieve your fitness goals?

6. Describe how you would feel once you achieve these goals: _____

7. How committed are you to achieving your fitness goals?

Not Committed 0 1 2 3 4 5 6 7 8 9 10 Very Committed

8. How is health prioritized in your life? Low [] Medium [] High []

9. What are some barriers that you have encountered in the past that prevent you from exercising?
(e.g. illness, injury, time)

10. Do you foresee any event that may impede progress with your exercise program in the future?
(e.g. travel, surgery, moving, work, other responsibilities)
