Personal Training
New Client Questionnaire

This information will be kept confidential. Please answer only what you feel comfortable sharing. The data we receive will help us personally tailor your training to fit your needs.

Basic Information:

Name _____ Date of Birth ____/_____/_____

Primary Phone Number: (Please circle: cell home other) _____

Emergency Contact: _____ Phone: _____

What days and times are best for you in your work-out routine? _____

How can a Personal Trainer help you? Please check all that apply.

- ❑ Lose Body Fat
- ❑ Increase Flexibility and Mobility
- ❑ Rehabilitate an Injury
- ❑ Start an Exercise Program
- ❑ Sports Specific Training
- ❑ Develop Muscle Tone
- ❑ Lose Weight
- ❑ Nutrition Education
- ❑ Design a More Advanced Exercise Program
- ❑ Increase Muscle Size

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Medical Related Questions:

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? _____ Yes _____ No

Do you frequently have pains in your chest when you perform physical activity?
_____ Sometimes _____ Often _____ Never

Have you had chest pains when you were not doing physical activity? _____ Yes _____ No

Do you lose your balance due to dizziness or do you ever lose consciousness?
_____ Sometimes _____ Often _____ Never

Are you pregnant now or have you given birth within the last 6 months? _____ Yes _____ No

Do you have bone, joint or any other health problems that cause 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…) (Please list):

_____

Have you had any surgeries or injuries? (Please list): _____

On a scale of 1 (lowest) to 10 (highest), what is your current stress level? _____

Lifestyle Related Questions:

How would you describe your normal daily activities? (Please check one.)

- ❑ **Sedentary:** Spend most of the day sitting (e.g. bank teller, desk job)
- ❑ **Lightly Active:** Spend a good part of the day on your feet (e.g. teacher, salesman)
- ❑ **Active:** Spend a good part of the day doing some physical activity (e.g. waitress, mailman)
- ❑ **Very Active:** Spend most of the day doing heavy physical activity (e.g. carpenter, landscaper)

Do you smoke? _____ Yes _____ No If yes, how many a day? _____

Do you drink? _____ Yes _____ No If yes, how many glasses per week? _____

Have you ever participated in sports or recreational activities?(e.g. golf, tennis) _____ Yes _____ No

Do you currently participate in any recreational activities? _____ Yes _____ No

If yes, what and how often?

_____

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Nutrition Related Questions:

Overall how would you rate your eating habits? (Please circle one.)

Very Healthy Somewhat Healthy Not Healthy

Do you take vitamins? _____ Yes _____ No If Yes, what kind? _____

How many glasses of water do you consume per day? _____

How many times a day do you eat (including snacks)? _____

Do you skip meals? _____ Yes _____ No

Do you eat breakfast? _____ Yes _____ No

Do you eat late at night? _____ Sometimes _____ Often _____ Never

Exercise Related Questions:

How often do you take part in physical activity? (Please circle one)

5-7 times/week 3-4 times/week 1-2 times/week None

How long have you been consistently active for? _____

Do you regularly walk or run 1 or more miles continuously? (If yes, what is your average number of miles you run and the time it takes to complete those miles.) _____ Yes _____ No

What activities are you presently involved in? (Please circle one)

Cardio Sports Strength Training Flexibility Exercises None

Are you accustomed to vigorous exercise? _____ Yes _____ No

Have you ever worked with a personal trainer before? _____ Yes _____ No

Do you have any preferences in your personal trainer? (e.g. Male or Female)

_____