Pulse Personal Training

CLIENT INFO

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 develop a program that is both safe and effective, while addressing your goals.

Name:_____ Date of Birth____/____/____ Age:_____
M D Y

Address:_____
Street City State Zip Code

Phone: _____(h) _____(o) _____(fax)

Email address: _____

Occupation:_____

Emergency Contact: _____ Relationship: _____

Phone Number:_____

Physician's Name:_____ Physician's Phone:_____

Physician's Address:_____
Street City State Zip Code

PAR-Q FORM

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?_____

2) Do you drink alcohol? YES NO If yes, how many drinks 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? ❍ 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 If yes, when?_____

9) Do you know how many calories you eat per day? YES NO If yes, how many?_____

10) At work or school, do you usually: ❍ Eat out ❍ Bring food

11) How many times per week do you eat out? _____

12) Do you do your own grocery shopping? YES NO

13) Do you do your own cooking? YES NO

14) Besides hunger, what other reason(s) do you eat?
❍ Boredom ❍ Social ❍ Stressed ❍ Tired ❍ Depressed ❍ Happy ❍ Nervous

15) Do you eat past the point of fullness? ❍ Often ❍ Sometimes ❍ Never

16) Do you eat foods high in fat and sugar? ❍ Often ❍ Sometimes ❍ Never

17) List 3 areas of your Nutrition you would like to improve:

a._____ b._____ c._____

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) How long have you been consistently physically active for? _____

4) What activities are you presently involved in?

Cardio &/or Sports Frequency/Week Average Length Easy/Mod/Hard

_____
_____
_____
___

Strength Training Frequency/Week Average Length Easy/Mod/Hard

_____
_

List exercises:_____
_____
_

Stretching Frequency/Week Average Length

_____
_

5) Please circle all the activities that interest you:

Baseball	Kayaking	Soccer
Basketball	Lacrosse	Swimming
Boxing	Partner Training	Tennis
Cross Country Skiing	Pilates	Triathlon
Cycling	Private Personal Training	Volleyball
Football	Racquetball	Walking
Golf	Rockclimbing	Snowshoeing
Group Fitness Classes	Indoor Cycling	Wallyball
Group Personal Training	Running	White Water Rafting
Hiking	Skiing	Yoga
Ice Skating	Snowboarding	Other:

Goal Setting:

How can a Personal Trainer 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_____

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 committed are you to achieving your fitness goals? ❍ Very ❍ Semi ❍ Not very

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