PERSONAL FITNESS QUESTIONNAIRE

Trainer: _____Date: _____

ASSESSING YOUR NEEDS:
All information received on this form will be treated as confidential. Please fill out this questionnaire completely and accurately. This information is essential in the development of a safe and effective program that will address your specific needs, goals, and interests.

Name:_____
Date of Birth:____/____/____ Age:_____

Address:_____
Street City State ZIP

Phone: (home)_____ (work) _____
(cell) _____ (fax) _____

Email address:_____

Company: _____Occupation:_____

Physician's Name/Phone:_____/_____
Address:_____
Street City State ZIP

What is your reason for investing in Personal Training?
(Please circle all that apply)

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

How did you hear about us? Please circle all that apply.

Brochure	Flyer

Word of Mouth Other _____

Personal Fitness

Presently, do you exercise on a regular basis? Yes ___ No ___
If yes, describe the exercise routine:

_____
_____
_____
_____

How many days per week do you exercise? _____
How many minutes each day? _____
How long have you been exercising regularly? _____years _____months
Are you trying to decrease body fat for good? ____yes ____ no
If yes, how many pounds do you want to get rid of? _____ lbs.
What is the most you have weighed as an adult? _____ lbs.
What is the least you have weighed as an adult? _____ lbs.

Assign a number 1 through 5 to rate the following statements according to your perception of the following:
(1 represents the lowest level, 5 represents the highest level)
How fit you currently feel
___ 1 ___ 2 ___ 3 ___ 4 ___ 5
The discipline you have to maintain a consistent workout routine on your own
___ 1 ___ 2 ___ 3 ___ 4 ___ 5
Your capacity for aerobic activity
___ 1 ___ 2 ___ 3 ___ 4 ___ 5
Your muscular strength
___ 1 ___ 2 ___ 3 ___ 4 ___ 5
Your body's flexibility
___ 1 ___ 2 ___ 3 ___ 4 ___ 5
Your current level of energy
___1 ___2 ___3 ___4 ___5
How much time will you devote to an exercise program?
_____ days per week _____ minutes per day
What exercises do you most enjoy?

_____
_____
_____

What exercises do you least enjoy?

_____
_____
_____

List any injuries that would inhibit an exercise program. List date/year injury began to inhibit exercise if relevant.

_____
_____
_____

Goal Setting

1. Please list in order of priority 3 fitness-based goals you would like to achieve over the next 3-6 months (a, b, c) and two long term goals that you would like to achieve in the next 1-2 years (d, e)? (Be specific and creative!)

a)_____
_____

b)_____
_____

c)_____
_____

d)_____
_____

e)_____
_____

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

_____
_____

3. What priority does health have in your life? Please circle.
Low priority Medium Priority High priority

4. How committed are you to achieving your fitness goals? Please circle.
Very Semi Not very

5. Outline any obstacles, potential actions, behaviors or activities that could limit 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.).

_____
_____
_____

DIET AND NUTRITION

How would you describe your daily nutritional habits?

____ unhealthy ____ erratic ____healthy

What about your daily nutritional habits prompted you to provide that answer?

_____

_____

List any medications you take on a regular basis. Include vitamins and supplements.

_____

_____

YOU ARE WHEN YOU EAT

1. Do you frequently skip meals?

___ Yes (3) ___ No (0)

2. Do you typically go more than four hours without eating?

___Yes (check option below) ___ No (0)

___ 1-2 times per week (1)

___ 3 times per week (2)

___ more than 3 times per week (3)

3. Do you sometimes skip breakfast?

___Yes (check option below) ___ No (0)

___ 2 times per week (1)

___ 3 times per week (5)

___ more than 3 times per week (10)

4. Do you avoid all types of fat when eating?

___ Yes (3) ___ No (0)

5. Do you frequently eat carbohydrates (i.e. breads, bagels, cookies, pasta, cereals, muffins, crackers, chocolate, or candy) by themselves?

___ Yes (5) ___ No (0)

6. Do you get hungry or crave sweets within two hours after eating a meal?

___ Yes (5) ___ No (0)

7. Do you use caffeine and/or sugar containing drinks (i.e. coffee, tea, sodas, fruit juices with sucrose, corn syrup or added sugar)?

___Yes (check option below) ___ No (0)

___ 1 cup a day (1)

___ 2 cups per day (3)

___ more than 2 cups per day (5)

8. Have you tried diets to lose weight?

___Yes (check option below) ___ No (0)

___ once (1)
___ twice (2)
___ three-five times (5)
___ more than five times (10)

9. Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?
___ Yes (3) ___ No (0)

10. Do you eat your largest meal at night?
___ Yes (1) ___ No (0)

Total: _____ Trainer's Opinion: _____

YOU ARE WHAT YOU EAT

1. Do you shop less frequently than every four days?
___ Yes (1) ___ No (0)

2. Do you eat more packaged (frozen or canned) fruits and vegetables than fresh?
___ Yes (3) ___ No (0)

3. Do you eat more cooked vegetables than raw?
___ Yes (3) ___ No (0)

4. Do you eat vegetables with less than two meals daily?
___ Yes (5) ___ No (0)

5. Do you buy more non-organic vegetables than organic vegetables?
___ Yes (5) ___ No (0)

6. Do you use a microwave oven to cook food?
___Yes (check option below) ___ No (0)
___ 1-2 times per week (2)
___ 3-4 times per week (5)
___ more than 4 times per week (10)

7. Do you eat quick cook grains such as Rice-aroni, Quaker Oats or Minute rice more often than slow cooked organic whole grains?
___ Yes (5) ___ No (0)

8. Do you eat white bread more often than whole grain breads?
___ Yes (5) ___ No (0)

9. Do you drink pasteurized/homogenized milk, or eat cheeses frequently?
___Yes (check option below) ___ No (0)

___ 1-2 times per week (1)
___ 3 times per week (3)
___ more than 3 times per week (5)

10.Do you eat non-organic yogurts that are low fat, presweetened or have fruit added?
___Yes (check option below) ___ No (0)
___ 1-2 times per week (1)
___ 3 times per week (3)
___ more than 3 times per week (5)

11. Do you eat typical store bought eggs from cage-raised chickens (as apposed to free range, grain fed eggs)?
___ Yes (5) ___ No (0)

12. Do you eat red meat more than once every four days?
___ Yes (3) ___ No (0)

13. Do you commonly eat meats (beef, chicken, turkey) from sources other than a free-range and hormone-free source?
___ Yes (3) ___ No (0)

14. Do you eat canned fish more frequently than fresh fish?
___ Yes (3) ___ No (0)

15. Do you use commercial salad dressings?
___ Yes (check option below) ___ No (0)
___ once a week (1)
___ twice per week (2)
___ more than 2 times per week (3)

16. Do you use Mayonnaise or products containing hydrogenated oils?
___Yes (check option below) ___ No (0)
___ once a week (1)
___ twice per week (2)
___ more than 2 times per week (5)

17. Do you eat nuts and/or seeds that are roasted and/or salted?
___ Yes (1) ___ No (0)

18. Do you use white table sugar as a sweetener?
___Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (3)
___ more than 3 times per week (5)

19. Do you use artificial sweeteners such as Sweet-n-Low, Equal or Nurtasweet?

___Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (5)
___ more than 3 times per week (10)

20. Do you use standard white table salt?
___ Yes (5) ___ No (0)

21. Do you eat TV dinners or other highly processed foods more than three times a week?
___ Yes (5) ___ No (0)

22. Do you eat from fast food restaurants like McDonald's, Arby's, Wendy's, etc?
___Yes (check option below) ___ No (0)
___ 1-2 times per week (2)
___ 3 times per week (5)
___ more than 3 times per week (10)

23. Do you eat from vending machines?
___Yes (check option below) ___ No (0)
___ 1-2 times per week (2)
___ 3 times per week (5)
___ more than 3 times per week (10)

24. Do you drink more than 5 glasses of water per day?
___ Yes (0) ___ No (10)

25. Do you eat some form of store bought dessert, such as ice cream, cookies, donuts, cakes or pies after dinner most nights?
___Yes (check option below) ___ No (0)
___ once a week (1)
___ 2-3 times per week (3)
___ more than 3 times per week (5)

Total: _____ Trainer's Opinion: _____

PAR – Q

Completed Yes_____ No_____
Medical Clearance Required Yes _____ No _____

RISK STRATIFICATION

Completed Yes_____ No_____
Risk for CAD Low_____ Moderate_____
High_____

Medical Clearance Required Yes_____ No_____

FITNESS ASSESSMENT

Completed Yes_____ No_____

Strengths:_____
_____
_____
_____
_____

Weeknesses:_____
_____
_____
_____
_____

RECOMMENDATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____

Personal Trainer _____ **Client** _____
Signature _____ **Signature** _____
Date_____ **Date** _____