

**NEW CLIENT QUESTIONNAIRE**

Please fill out this form *completely and accurately*.

- This information is essential to helping your trainer develop a program that addresses your needs, goals and interests and is safe and effective.
- All information received on this form will be treated as strictly confidential.

Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
M D Y

Address: \_\_\_\_\_  
Street City State Zip Code

Phone:(h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
~PLEASE CHECK THE BEST NUMBER(S) TO REACH YOU~

The best time to call is \_\_\_\_\_. Please don't call before \_\_\_ am or after \_\_\_ pm

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
Street City State Zip Code

**Please provide 48 hours notice if you need to reschedule your appointment.**

**For office use only:**

**Personal Trainer:** \_\_\_\_\_ **1<sup>st</sup> Appointment:** \_\_\_\_\_

# Health History Form

Do you now, or have you had in the past:

- 1) History of heart problems, chest pain or stroke..... YES NO
- 2) Increased blood pressure..... YES NO
- 3) Any chronic illness or condition..... YES NO
- 4) Difficulty with physical exercise..... YES NO
- 5) Advice from physician NOT to exercise..... YES NO
- 6) Recent surgery (past 12 months)..... YES NO
- 7) Pregnancy (now or within past three months)..... YES NO
- 8) History of breathing or lung problems..... YES NO
- 9) Muscle, joint or back disorder, or previous injury still affecting you..... YES NO
- 10)Diabetes or thyroid condition..... YES NO
- 11)Cigarette smoking habit..... YES NO
- 12)Obesity (more than 20% over ideal body weight).....YES NO
- 13)Increased blood cholesterol..... YES NO
- 14)History of heart problems in immediate family..... YES NO
- 15)Hernia, or any condition that may be aggravated by lifting weights.....YES NO

Please explain any “yes” answers:

---

---

16)Are you taking any medications (either prescription or over-the-counter), which may affect your ability to exercise?

---

---

17) Is your physician aware you are participating in an exercise program? ... **YES NO**

**Lifestyle Related Questions:**

1) Describe your job:

- Sedentary
- Active
- Physically Demanding
- Requires Travel

2) Would an exercise program interfere with your job? ..... **YES NO**

3) Would an exercise program benefit your job? ..... **YES NO**

4) Can you exercise during your work day, or is your schedule flexible? ... **YES NO**

5) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)?

1      2      3      4      5      6      7      8      9      10

6) Is anyone in your family overweight? ..... **YES NO**

- Mother
- Father
- Sibling
- Grandparent

7) Were you overweight as a child? ..... **YES NO**

**Fitness History:**

1) On a scale of 1-10, how would you rate your present fitness level ?

1   2      3      4      5      6      7      8      9      10

2) When were you in the best shape of your life? \_\_\_\_\_

3) Were you a high school or college athlete? ..... **YES NO**  
If yes, what sport(s)? \_\_\_\_\_

4) When you exercise, participate in an event or sport, how important is competition?

1   2      3      4      5      6      7      8      9      10

5) Has your weight changed by 10 lbs. or more in the past year? ..... **YES NO**  
If YES, how many pounds? (+) \_\_\_\_\_ (-) \_\_\_\_\_

**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 Time
- Lack of Interest
- Illness/Injury
- Other \_\_\_\_\_

3) How long have you been consistently physically active? \_\_\_\_\_

4) What activities are you presently involved in?

**Cardio**

Frequency: (times per week):      1-2    2-3    3-4    4-5    5+

Duration: (minutes per session): \_\_\_\_\_

Intensity Level (scale of 1-10): \_\_\_\_\_

Type of exercise: \_\_\_\_\_

**Sports**

Type of sport(s): \_\_\_\_\_

**Strength Training**

Frequency: (times per week):      1-2    2-3    3-4    4-5

Intensity level:                      Easy                      Medium                      Hard

**Stretching**

Frequency: (times per week):      1-2    2-3    3-4    4-5    5+

5) Please check all the activities that interest you:

- |  |                                      |  |                                    |
|--|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Aerobic Classes | <input type="checkbox"/> Hiking      | <input type="checkbox"/> Rollerblading | <input type="checkbox"/> Tennis    |
| <input type="checkbox"/> Baseball        | <input type="checkbox"/> Ice Skating | <input type="checkbox"/> Running       | <input type="checkbox"/> Triathlon |

- |   |   |                                       |  |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Basketball           | <input type="checkbox"/> Indoor Cycling | <input type="checkbox"/> Skiing       | <input type="checkbox"/> Volleyball          |
| <input type="checkbox"/> Bicycling (outdoors) | <input type="checkbox"/> Kayaking       | <input type="checkbox"/> Snowboarding | <input type="checkbox"/> Walking             |
| <input type="checkbox"/> Cross Country Skiing | <input type="checkbox"/> Orienteering   | <input type="checkbox"/> Snowshoeing  | <input type="checkbox"/> White Water Rafting |
| <input type="checkbox"/> Canoeing             | <input type="checkbox"/> Pilates        | <input type="checkbox"/> Soccer       | <input type="checkbox"/> Yoga                |
| <input type="checkbox"/> Golf                 | <input type="checkbox"/> Racquetball    | <input type="checkbox"/> Swimming     | <input type="checkbox"/> Others: _____       |

**Nutrition Related Questions**

1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)?

- 1      2      3      4      5      6      7      8      9      10

2) Would you make better food choices/improve eating habits if you were held accountable?.....YES NO

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

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

**Developing your Fitness Program:**

1) Where would you prefer to exercise? (check all that apply):

- Indoors...at studio
- Indoors...at home
- Outdoors

2) With whom would you prefer to exercise? (check all that apply):

- Alone
- Friend/Spouse
- Small Group

3) When would you prefer to exercise? (check all that apply):

- Early morning
- Mid-Morning
- Noon
- Afternoon
- Evening

4) Realistically, how often each week would you like to exercise?

- 2-3

- 3-4
- 4-5

5) Realistically, how much time would you like to spend during each exercise session?

- 30 minutes
- 45 minutes
- 60 minutes
- More

6) What are the best days during the week for you to commit to your exercise program?

M    T    W    T    F    Sa    Su

**Goal Setting:**

**How can a Personal Trainer help you? Please check that which applies.**

- |  |   |
|--|---|
| <input type="checkbox"/> Start Exercising    | <input type="checkbox"/> Sport specific training: _____ |
| <input type="checkbox"/> Lose body fat       | <input type="checkbox"/> Rehabilitate an Injury: _____  |
| <input type="checkbox"/> Nutrition Education | <input type="checkbox"/> Design a more advanced program |
| <input type="checkbox"/> Develop Muscle Tone | <input type="checkbox"/> Increase Muscle Size           |
| <input type="checkbox"/> Motivation          | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> Safety              |   |

1. In the following space, write down the fitness goals you would like to achieve. List **anything** you have ever thought of achieving with regards to your own individual health and fitness.

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

2. On a scale of 1-10 how ready are you to make Health and Fitness a priority in your life? (1=low, 10=high)

1    2    3    4    5    6    7    8    9    10

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

---



---

- 
4. What do you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals
- not training consistently/not sticking to plan
  - travel business/vacation
  - holiday season
  - busy season at work
  - family commitments
  - other responsibilities become a priority\_\_\_\_\_

5. Outline some ways that you plan to use to overcome these obstacles:

---

---

**Miscellaneous Questions:**

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

- Brochure
- Drop-in
- Word of Mouth-referral
- Chamber of Commerce
- Yellow Pages
- Website
- Other\_\_\_\_\_

2. If you were referred to us, who told you about our services?

---

3. What would cause you to discontinue training with us?

---

**Thank you for this opportunity to help you achieve your PERSONAL BEST!**