free2befitness

New Client Intake

PERSONAL INFORMATION

Name:_____ height & weight:

Email: _____ date of birth:

Phone: _____ occupation:

Emergency Contact (name, relationship, phone #)

BACKGROUND & GOALS

What is motivating you to meet with a personal trainer? Please list any specific goals you are looking to achieve.

Describe your current level of activity? (recreational physical activity)

Have you exercised in the past? Please describe.

Please describe any injuries, chronic pain or medical conditions that may affect your ability to exercise.

Do you have any concerns about starting a new exercise program?

SLEEP HABITS

How would you describe your overall sleep quality?

EXCELLENT GOOD FAIR POOR

How many hours of sleep do you get on an average night?

NUTRITION

How would you describe your eating habits?

Do you eat breakfast every day? YES NO

How much water do you drink on a daily basis?

Do you have any dietary restrictions?

Do you currently monitor your food intake in any way?

How frequently do you cook at home?

STRESS EVALUATION

Mark the number that best describe the degree to which each statement applies to you.

0=never 1=almost never 2=sometimes 3=fairly often 4=very often

I suffer from physical aches and pains; sore back, headaches, stiff neck, stomach aches _____

I feel slow and tired

I consider myself "stressed"

HEALTH HISTORY

If you answer "yes" to any of the following questions, please provide details such as date of occurrence, frequency, intensity, etc..

YES NO Do you have high blood pressure or high cholesterol?

YES NO Are you epileptic?

YES NO Do you suffer from asthma or exercise induced asthma?

YES NO Are you pregnant?

Yes NO Have you ever had surgery or broken any bones?

YES NO Do you experience stiff, swollen or painful joints?

YES NO Have you ever been advised by a physician to avoid any type of exercise?

YES NO Have you ever been knocked unconscious or suffered a concussion?

YES NO Do you (or does someone in your family) have a cardiac condition?

YES NO Do you have any known allergies?

YES NO Are you currently taking any medications?

YES NO Do you currently smoke marijuana or cigarettes or have you smoked in the past?

YES NO Do you drink alcohol?

Additional Information:

_____ _____

Client Signature Date