Personal Training Questionnaire

Instructions: Please fill out the following information as completely as possible. The fitness program designed for you will be based on the information in this form. After you have completed the form, please return it to the member services desk. After a personal trainer has reviewed the form, he/she will call you to set up the first training session.

Name: Date:

Home Phone: Work Phone: DOB:

Address: Age:

E-mail Address:

Employer/Occupation:

How many hours do you work per week? < 35 ☐ 35-40 ☐ 40-45 ☐ 45-50 ☐ > 50 ☐

What are the primary physical requirements of your job?

Phone/computer ☐ Sitting ☐ Standing ☐ Lifting ☐ Travel ☐

Please rate your level of stress on the following scale (circle one)

Home:	Low Stress	1	2	3	4	5	High Stress
Work:	Low Stress	1	2	3	4	5	High Stress

Please list a relative whom we may contact in case of an emergency.

Name: Relation:

Home Phone: Work Phone:

Please complete the information for your personal physician.

Name of Physician:

Address:

Office Phone: Office Fax:

Family Health History

Please indicate if you have any *primary relatives* who have any of the following conditions. (check all that apply)

Asthma	☐	Cancer	☐	Hypertension	☐	High Cholesterol	☐
Arthritis	☐	Diabetes	☐	Heart Disease	☐	Osteoporosis	☐
Obesity	☐	Stroke	☐	Other:			

Please provide a brief explanation for any of the above that have been checked.

Personal Health History

Please indicate if *you* have any of the following conditions. (check all that apply).

Asthma	☐	Cancer	☐	Hypertension	☐	High Cholesterol	☐
Arthritis	☐	Diabetes	☐	Heart Disease	☐	Osteoporosis	☐
Obesity	☐	Stroke	☐	Other:			

Please provide a brief explanation for any of the above that have been checked.

Please indicate if you have had any joint injuries or surgeries that may limit or effect your ability to exercise.

Neck	☐	Hip	☐	Wrist/Hand	☐
Shoulder	☐	Knee	☐	Ankle/Foot	☐
Elbow	☐	Low Back	☐	Other	☐

Please provide a brief explanation for any of the above that have been checked.

Please indicate any medications currently used.

Type of Medication	Purpose

Do you smoke cigarettes? Yes ☐ No ☐ If yes, how often? _____

Are you a past smoker? Yes ☐ No ☐ If yes, when did you quit? _____

Do you drink alcoholic beverages? Yes ☐ No ☐ If yes, how much, often? _____

Are you presently dieting or on a weight control program? Yes ☐ No ☐

If yes, please provide a brief explanation. _____

Do you have any past or present medical conditions, not already addressed, which may influence your ability to safely participate in an exercise program? If yes, please explain.

Please provide a brief explanation of your current exercise program. Include types of activity and frequency.

What are your current health and fitness goals? Please be as specific as possible.

Do you foresee any barriers that may prevent you from adhering to a regular exercise program?

How do you rate your level of motivation and commitment to achieving your goals? (circle one)

Low 1 2 3 4 5 High

Have you worked with a personal trainer in the past? Yes ☐ No ☐

When are you available to meet with a trainer?

Morning ☐ Day ☐ Evening ☐ Other: _____

Do you prefer to work with a male or female trainer? Male ☐ Female ☐ No preference ☐

If you have a specific Trainer you want to work with list here: _____

Payment for Personal Training must be attached to this questionnaire Training will not begin with out it..