Sports Enhancement 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:

Sport:

Coach's Name:

Sport:

Coach's Name:

What are the primary goals for your sport?

☐ Speed ☐ Quicker ☐ Stronger ☐ Endurance ☐ Explosive

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

Main School Sport:	Low	1	2	3	4	5	High
Secondary Sport or Club Sport:	Low	1	2	3	4	5	High

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 impact 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 use supplements? Yes ☐ No ☐ If yes, which ones, how 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 specific explanation of your current exercise program. Include types of activity and frequency.

What other sport related goals do you have? Please be as specific as possible.

Do you foresee any barriers that may prevent you from adhering to this program? (vacation, work, prior commitments, and/or team responsibilities)

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 strength coach or certified trainer in the past? Yes ☐ No ☐
If yes, who and where? _____

When are you available to meet with a trainer?

Morning ☐ Mid-Day ☐ Evening ☐ Other: _____

Days: **M** **T** **W** **TH** **F** **SAT** **SUN**

Time of Day:

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

Payment for Enhancement Training must be attached to this questionnaire. Training will not begin without payment.