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.

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<th>Type of Medication</th>
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Do you smoke cigarettes?

Yes ☐ No ☐ If yes, how often?

Yes ☐ No ☐ If you are 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 without it.