

PERSONAL TRAINING CLIENT INFORMATION QUESTIONNAIRE



NOTE: Please complete prior to your first session

Name: _____

Date: _____

OFFICE USE ONLY:

Body Weight: _____ Body Fat: _____ BMI: _____
Max Push Ups: _____ Max Pull Ups: _____ Max ISO Squat: _____
Max Crunches (1 min): _____

CLIENT INFORMATION QUESTIONNAIRE

Please completed and return or email to your Personal Trainer at the beginning of your first scheduled session.

All information received on this form will be treated as strictly confidential. Please fill out the forms 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.

Name:	_____	Date of Birth:	_____	Age:	_____
Address:	_____				
	Street	City	Province	Postal Code	
Phone:	_____				
	Home	Office	Fax		
Email:	_____				
Occupation:	_____				
Emergency Contact:	_____				
	Name	Relationship	Phone Number		
Physician's Name:	_____	Physician's Phone:	_____		
Physicians's Address:	_____				
	Street	City	Province	Postal Code	

Please provide 24 hours notice if you need to cancel or reschedule your Personal Training appointment.

Personal Trainer: _____
1st Appointment: _____

PAR-Q FORM

Please mark YES or No to the following:

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you frequently have pains in your chest when you perform physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had chest pain when you were not doing physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you lose your balance due to dizziness or do you ever lose consciousness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant now or have given birth within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a recent surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have marked YES to any of the above, please elaborate below:	
Do you take any medications, either prescription or non-prescription, on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the medication for?	
How does this medication affect your ability to exercise or achieve your fitness goals?	

Lifestyle Related Questions

1) Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many?
2) Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many glasses per week?
3) How many hours do you regularly sleep at night?		
4) Describe your job:	<input type="checkbox"/> Sedentary <input type="checkbox"/> Active <input type="checkbox"/> Physically Demanding	
5) Does your job require travel?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6) On a scale of 1-10, how would you rate your stress level (1=very low - 10=very high)?		
7) List your 3 biggest sources of stress:		
a.	b.	c.
8) Is anyone in your family overweight?	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grand Parent	
9) Were you overweight as a child?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, at what age(s)?

Fitness History

1) When were you in the best shape of your life?
2) Have you been exercising consistently for the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
3) When did you first start thinking about getting in shape?
4) What if anything stopped you in the past?
5) On a scale of 1-10, how would you rate your present fitness level (1=Worst - 10=Best)?

Nutrition Related Questions

1) On a scale of 1-10, how would you rate your Nutrition (1=very poor - 10=excellent)?	
2) How many times a day do you usually eat (including snacks)?	
3) Do you skip meals? <input type="checkbox"/> Yes <input type="checkbox"/> No	4) Do you eat breakfast? <input type="checkbox"/> Yes <input type="checkbox"/> No
5) Do you eat late at night? <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Never	
6) What activities do you engage in while eating? (TV, reading etc)	

7) How many glasses of water do you consume daily?		
8) Do you feel drops in your energy levels throughout the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?
9) Do you know how many calories you eat per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many?
10) Are you currently or have you ever taken a multivitamin or any other food supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list the supplements:		
11) At work or school, do you usually: <input type="checkbox"/> Eat Out <input type="checkbox"/> Bring Food		
12) How many times per week do you eat out?		
13) Do you do your own grocery shopping? <input type="checkbox"/> Yes <input type="checkbox"/> No		
14) Do you do your own cooking? <input type="checkbox"/> Yes <input type="checkbox"/> No		
15) Besides hunger, what other reason(s) do you eat? <input type="checkbox"/> Boredom <input type="checkbox"/> Social <input type="checkbox"/> Stressed <input type="checkbox"/> Tired <input type="checkbox"/> Depressed <input type="checkbox"/> Happy <input type="checkbox"/> Nervous		
16) Do you eat past the point of fullness? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never		
17) Do you eat foods high in fat and sugar? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never		
18) List 3 areas of your Nutrition you would like to improve:		
a.	b.	c.

Exercise Related Questions (Skip to next section if you are presently inactive.)

1) How often do you take part in physical exercise? <input type="checkbox"/> 5-7x/week <input type="checkbox"/> 3-4x/week <input type="checkbox"/> 1-2x/week			
2) If your participation is lower than you would like it to be, what are the reasons? <input type="checkbox"/> Lack of Interest <input type="checkbox"/> Illness/Injury <input type="checkbox"/> Lack of Time <input type="checkbox"/> Other:			
3) How long have you been consistently physically active for?			
4) Please select all the activities that interest you:			
<input type="checkbox"/> Aerobic Fitness Classes	<input type="checkbox"/> Hiking	<input type="checkbox"/> Rockclimbing	<input type="checkbox"/> Triathlon
<input type="checkbox"/> Baseball	<input type="checkbox"/> Ice Skating	<input type="checkbox"/> Running	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Basketball	<input type="checkbox"/> Indoor Cycling	<input type="checkbox"/> Skiing	<input type="checkbox"/> Walking
<input type="checkbox"/> Boxing	<input type="checkbox"/> Kayaking	<input type="checkbox"/> Snowboarding	<input type="checkbox"/> Wallyball
<input type="checkbox"/> Cross Country Skiing	<input type="checkbox"/> Partner Training	<input type="checkbox"/> Snowshoeing	<input type="checkbox"/> White Water
<input type="checkbox"/> Football	<input type="checkbox"/> Pilates	<input type="checkbox"/> Soccer	<input type="checkbox"/> Rafting
<input type="checkbox"/> Golf	<input type="checkbox"/> Private Personal Training	<input type="checkbox"/> Swimming	<input type="checkbox"/> Yoga
<input type="checkbox"/> Group Personal Training	<input type="checkbox"/> Racquetball	<input type="checkbox"/> Tennis	

Developing your Fitness Program

1. Please circle how you prefer to exercise:						
a. <input type="checkbox"/> Inside	<input type="checkbox"/> Outside	<input type="checkbox"/> Combination				
b. <input type="checkbox"/> Large Groups	<input type="checkbox"/> Small Groups	<input type="checkbox"/> Alone	<input type="checkbox"/> Combination			
c. <input type="checkbox"/> Morning	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Evening				
2. Realistically, how often a week would you like to exercise?						x / week
3. Realistically, how much time would you like to spend during each exercise session?						
4. What are the best days during the week for you to commit to your exercise program? <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun						
5. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Goal Setting

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Lose Body Fat | <input type="checkbox"/> Develop Muscle Tone | <input type="checkbox"/> Rehabilitate an Injury | <input type="checkbox"/> Nutrition Education |
| <input type="checkbox"/> Start an Exercise Program | <input type="checkbox"/> Design a more advanced program | | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Sports Specific Training | <input type="checkbox"/> Increase Muscle Size | <input type="checkbox"/> Fun | <input type="checkbox"/> Motivation |
| <input type="checkbox"/> Other: | | | |

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

- a. _____
b. _____
c. _____

2. How will you feel once you've achieved these goals? Be specific.

3. Where do you rate health in your life? Low priority Medium Priority High priority

4. How committed are you to achieving your fitness goals? Very Semi Not very

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

6. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc.).

7. Outline 3 methods that you plan to use to overcome these obstacles:

a. _____ b. _____ c. _____

Miscellaneous Questions

1. How did you hear about us? Please check that which applies.

- | | | |
|-----------------------------------|--|----------------------------------|
| <input type="checkbox"/> Brochure | <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Website |
| <input type="checkbox"/> Other: | | |

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

3. Why did you choose to train with Strive Fitness instead of another organization? Please check that which applies.

- | | | | |
|--|--|---------------------------------|---|
| <input type="checkbox"/> Location | <input type="checkbox"/> Personal Trainers | <input type="checkbox"/> Cost | <input type="checkbox"/> Customer Service |
| <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Programs | <input type="checkbox"/> Other: | |

4. How far do you live from our training studio? _____ kilometers

5. Which newspaper(s) do you read?

6. Which radio station(s) do you listen to?

7. Which local magazine(s) do you read?

8. Which local morning TV show do you watch?

9. What would cause you to discontinue training with Strive Fitness?

10. The Gift of Fitness:

At Your Body You, we rely on happy clients telling others about our services. We may both be able to make a huge difference in somebody's life.

**Please take 3 business cards
If they buy a package with me, you receive a free session.**

READINESS

At Your Body You we generally know within a few minutes whether a client will succeed easily or not. If a client accepts our recommendations for changes to their exercise or nutrition program immediately and unconditionally, we know we will achieve success easily. If a client begins to make excuses or give reasons they feel they will not be able to adhere to the program, we can generally expect struggles throughout the process. We supply the following questionnaires to clients to help us determine where they are on the readiness scale. If you score low, this may not be the best time for you to initiate major changes to your lifestyle. It does not mean, however, that you cannot begin an exercise program. You can still initiate the program and start to develop patterns, but you should have lower expectations of yourself. If you score moderately, expect a few struggles on route towards your goals. If you score high, this is the perfect time for you to begin taking action towards your goals.

Readiness questionnaire I

1. Do you feel you are at some sort of health risk because of your current behaviors/lifestyle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you feel that making lifestyle changes will improve your quality of life and decrease your risk of health-related disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you view your health and fitness program as a lifetime goal rather than a short-term temporary goal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you willing to get personally involved in planning a health and fitness program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you willing to try different approaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have the patience to accept success in small increments and deal with possible setbacks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you willing to set realistic goals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you willing to make lifestyle changes?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered yes to all these questions, you are ready for action! If you said no to one or more of the questions, you might experience resistance as you begin to initiate many of the actions required to achieve your goals. It may be helpful for you to review what is re y important to you and learn more about the negative effects of your current behavior and the benefits of change.

Readiness questionnaire II

1. Compared to previous attempts, how motivated are you this time to adhere to your exercise program?	Not at all motivated <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Extremely motivated
2. How certain are you that you will stay committed to an exercise program for the time it will take to reach your goal?	Not at all certain <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Extremely certain
3. Considering all outside factors in your life-work, stress, family obligations etc. - to what extent can you tolerate the effort required to stick to a lifetime exercise and nutrition plan?	Can not tolerate <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Can tolerate easily
4. Think honestly about your goals. How realistic are they?	Very unrealistic <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Very realistic
5. Do you fantasize about eating a lot of your favorite foods?	Always <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Never
6. How confident are you that you can work regular exercise into your daily schedule, starting tomorrow?	Not at all confident <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Extremely Confident
Score: 6-12: Low motivation 13-25: Moderate motivation 25+: High motivation	

PERSONAL TRAINING PARTICIPANT RELEASE AND KNOWLEDGE OF AGREEMENT

1) I, _____, wish to participate in the exercise and training program offered by Your Body You. I understand that there are inherent risks in participating in a program of strenuous exercise. Consequently, I have been examined by a physician of my choice and have obtained his/her approval for my participation in a fitness program within sixty (60) days of the date set forth below. No change has occurred in my physical condition since the date such approval was given which might affect my ability to participate in the fitness program. If a physician has not examined me, I agree to see a physician within sixty (60) days of the date set forth below to obtain his/her approval for my participation in a fitness program. I agree that Your Body You shall not be liable or responsible for any injuries to me resulting from my participation in the fitness program (whether at home, or anywhere else outside of the facility) and I expressly release and discharge Your Body You, its owners, employees, agents and/or assigns, from all claims, actions, judgments, and the like which I or my heirs, executors, administrators or assigns may have or claim to have as a result of any injury or other damage which may occur in connection with my participation in the fitness program, excepting only an injury caused by the gross negligence or intentional act of such person or persons. This Release shall be binding upon my heirs, executors, administrators and assigns.

2) I certify that the answers to the questions outline on the PAR-Q form are true and complete to the best of my knowledge. I acknowledge that medical clearance is required if I have answered "Yes" to any of the questions on the PAR-Q form. I understand and agree that it is my responsibility to inform my Personal Trainer of any conditions or changes in my health, now and on-going which might affect my ability to exercise safely and with minimal risk of injury.

3) I understand that I am not obligated to perform nor participate in any activity that I do not wish to do, and that it is my right to refuse such participation at any time during my training sessions. I understand that should I feel lightheaded, faint, dizzy, nauseated, or experience pain or discomfort, I am to stop the activity and inform my Personal Trainer.

4) I understand the results of any fitness program cannot be guaranteed and my progress depends on my effort and cooperation in and outside of the sessions.

5) I understand that all personal training rates are based on 55 minute sessions (except specialty programs) and should I arrive late, there is no guarantee I will receive the full session with my trainer. In return, if my Personal Trainer is late for a session, I will still receive the full session time.

3) I understand that I am not obligated to perform nor participate in any activity that I do not wish to do, and that it is my right to refuse such participation at any time during my training sessions. I understand that should I feel lightheaded, faint, dizzy, nauseated, or experience pain or discomfort, I am to stop the activity and inform my Personal Trainer.

4) I understand the results of any fitness program cannot be guaranteed and my progress depends on my effort and cooperation in and outside of the sessions.

6) I understand that Your Body You bills its personal training clients on a pre-pay basis. Once my trainer and I have decided upon the number of sessions I will purchase, payment must be made before the sessions are conducted. Checks are to be made payable to Your Body You. I understand that all Personal Training sessions are non-refundable. I also understand that all Personal Training sessions must be redeemed within one year of purchase.

7) I understand that Your Body You operates on a scheduled appointment basis and thus, requires that I provide 24 hours notice when canceling an appointment. No charge will be levied should I cancel with MORE than 48 hours notice given. Should I cancel a session with 24 hours prior notice, I will be charged 50% of the charged fee for that session. Should I cancel a session with LESS than 24 hours prior notice, I will be charged in full for that session. I understand that Your Body You recommends that all canceled sessions be rescheduled to ensure consistency and fitness progress.

8) I understand that during a personal training session, touch can be used to correct my alignment and/or focus my concentration on a particular muscle area to be targeted, by touching the targeted area. If I feel uncomfortable or experience any type of discomfort, I will immediately request that my trainer discontinue touching me in any way.

9) I understand that the usage of any nutritional supplements is done under my own will and has not been prescribed by my Personal Trainer.

I have read this Release and Terms of Agreement and I understand all of its terms. I sign it voluntarily and with full knowledge of its significance.

PRINTED CLIENT NAME

CLIENT SIGNATURE

DATE