# Client Information

## Contact Info

Name: ______________________________________

Date of birth: ________________________________
*month* *day* *year*

Address: ____________________________________

City: ________________ Prov: _____________ Postal Code: ____________________

Phone: (c) ______________ (h) ___________________ (w)___________________

e-mail: ________________________ Occupation: ________________________

Emergency Contact: ________________________ Relationship: ____________________

Phone:______________________________

Physician's Name: _____________________ Physician's Phone: ____________________

## Medical Information

Are you taking any medications or drugs? ❑ Yes ❑ No

If YES, please list medication, dose and reason:

Medication:__________________________________

Reason: ____________________________________

Medication:__________________________________

Reason: ____________________________________

Medication:__________________________________

Reason: ____________________________________

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Do you have family history of the following:

Heart Attack ❑ Yes ❑ No
Heart Disease ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Angina ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Metabolic Condition ❑ Yes ❑ No

If you have answered yes to any of the above, please explain:

___

___

## Lifestyle Information

How many hours do you sleep at night? ❑ Less than 5 ❑ 6 ❑ 7 ❑ 8 ❑ more than 8

Describe your job: ❑ sedentary ❑ moderately ❑ active ❑ very active

Does your job require you to travel? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No If yes, how many cigarettes a day? ___________

Do you drink alcohol? ❑ Yes ❑ No

On a scale of 1 –10 how would you rate your stress level?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Describe your 3 biggest sources of stress:
1. ___
2. ___
3. ___

## Fitness Related Information

Describe any physical activity you do regularly.

| Activity | Frequency *(per week)* | Duration *(minutes)* | Intensity |
|---|---|---|---|
| | | | ❑ easy ❑ moderate ❑ hi |
| | | | ❑ easy ❑ moderate ❑ hi |
| | | | ❑ easy ❑ moderate ❑ hi |
| | | | ❑ easy ❑ moderate ❑ hi |



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Strength Training Frequency/week: _______ Duration per session (minutes) _________

Stretching Frequency/week: ________ Duration per session (minutes) ______________

Have you been exercising consistently for the past 3 months? ❑ Yes ❑ No

At what age did you start thinking about getting into shape? ___________

What, if anything has stopped you from exercising in the past? ___________________________

On a scale of 1-10, how would you rate your present fitness level?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What types of exercise interest you? *Check which ones apply*

❑ *walking* ❑ *running* ❑ *indoor cycling* ❑ *rowing* ❑ *swimming* ❑ *cycling* ❑ *tennis*
❑ *soccer* ❑ *pilates* ❑ *yoga* ❑ *basketball* ❑ *football* ❑ *bootcamp* ❑ *snowshoeing*
❑ *golf* ❑ *tai-chi* ❑ *triathlon* ❑ *hiking* ❑ *aerobics* ❑ *strength training*
❑ *raquetball or squash* ❑ *snowboarding* ❑ *water running* ❑ *one on one training*
❑ *other* ___________________________________________________

## Fitness Program Goals

How much time are you willing to devote to an exercise program?

Min/Day: ___________________ Days/Week: ______________________________

How can a Personal Trainer help you? *Check all that apply*

- ❑ Improve cardiovascular fitness and endurance
- ❑ Body-fat/weight loss
- ❑ Re-shape and tone my body
- ❑ Sport Specific Training
- ❑ Improve flexibility
- ❑ Increase strength
- ❑ Improve balance
- ❑ Increase bone density
- ❑ Nutrition

Please list the top three fitness goals that you would like to achieve in the next 12 months:

1. _______________________________________________

2. _______________________________________________

3. _______________________________________________

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