it's time!
Fitness Results

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PERSONAL TRAINING LIFESTYLE QUESTIONAIRE

Please take the time to fill out this questionnaire as thoroughly as possible so your Personal Training Program can be designed to meet your individual needs and goals.

Date: _____ Full Name: _____ Age: _____

Emergency Contact: _____

Physician's Name: _____ Phone: _____

How did you hear about us? _____

Goals:
Please describe your training goals, as precisely as you can:

- ☐ General health enhancement
- ☐ Decrease body fat/Weight loss.
  Change weight (+) (-) _____lbs
- ☐ Improve self esteem
- ☐ Improve overall appearance or specific area.
- ☐ List areas of your body you would like to improve _____
- ☐ Improve flexibility. List "tight" areas_____
- ☐ Improve balance
- ☐ Improve performance in sport Specify _____
- ☐ Increase Muscular Strength
- ☐ Muscular Endurance
- ☐ Reshape/Tone Body
- ☐ Body Building
- ☐ Improve ability to cope with Stress
- ☐ Decrease Blood Pressure or Cholesterol
- ☐ Increase energy level
- ☐ Enjoyment/Social
- ☐ Knowledge/Education
- ☐ OTHER

Describe_____

How old are your running shoes? _____

Do you have a physically demanding job? _____ YES _____ NO

How many hours do you sit at a desk per day? _____

Do you suffer from any kind of pain? _____

Have you been treated by a Chiropractor, Massage Therapist or Physiotherapist?

When? _____ Why? _____

If you have any physical problems or limitations, chronic ailments or injuries that may affect your ability to train, please describe those here. (Surgery, broken bones, stiff joints)
_____

Rate yourself on a scale of 1 to 5 (low =1 high =5). Circle the number that applies:

Characterize your present athletic ability.	1	2	3	4	5
When you exercise, how important is competition?	1	2	3	4	5
Characterize your present cardiovascular capacity.	1	2	3	4	5
Characterize your present muscular capacity.	1	2	3	4	5
Characterize your present flexibility capacity.	1	2	3	4	5

Nutrition

How many meals do you consume during a normal day?

☐ Breakfast, Always? Yes/No ☐ Lunch ☐ Dinner

Do you snack between meals? _____

Is healthy eating a challenge? _____

How many fruit and vegetable servings do you average per day? Fruits ___ Vegetables____

How much water do you drink daily? _____

How much coffee do you consume daily? _____

Do you drink alcohol, including beer and wine? _____ YES _____ NO
If yes, # drinks_____ # days _____/week

What medication(s)/supplements, including vitamins, herbs, etc., do you take regularly?
_____

What are your normal sleep patterns, e.g., about how many hours do you sleep each night, and do you have regular sleep/wake times? _____

Are there any unusual stresses in your life that may affect your training?
e.g., frequent business travel, shift work, family responsibilities? If so, please describe those here:
_____

Additional Comments welcome here: _____
_____