Intake Questionnaire

Initials _____

Name:

Birth date:

Age: Weight: Height:

Please answer YES or NO to the following:

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? YES NO

Do you frequently have pains in your chest when you perform physical activity? YES NO

Have you had chest pain when you were not doing physical activity? YES NO

Do you lose your balance due to dizziness or do you ever lose consciousness? YES NO

Do you have any current or previous 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.)? YES NO

If yes, please explain:

Are you pregnant now or have given birth within the last 6 months?

If yes, have there been or were there any complications?

Have you had a recent surgery?

If yes, please explain:

Do you take any medications, either prescription or non-prescription? YES NO

If yes, what is/are the medication(s), and what are they for?

Does this medication affect your ability to exercise or achieve your fitness goals? YES NO

If yes, how?

Lifestyle Related Questions:

Do you smoke cigarettes? YES NO If yes, how many per day?

Do you drink alcohol? YES NO If yes, how many drinks per week?

How many hours do you regularly sleep at night?

What is your job?

Describe your job: ❍Sedentary ❍Active ❍Physically demanding

Does your job require travel? YES NO

On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)?

List your 2 biggest sources of stress: 1. _____2. _____

Nutrition Related Questions:

What does a typical day of eating look like for you?

Breakfast (Time:)

Lunch (Time:)

Dinner (Time:)

Snack (Time:)

Do you have any food allergies?

If yes, please describe:

Do you eat late at night? ❍Often ❍Sometimes ❍Rarely ❍Never

How many 12oz. glasses of water do you consume daily?

Do you know how many calories you eat per day? YES NO

If yes, how many?

Do you have regular bowel movements? (1x/day average) YES NO

Are you currently or have you ever taken a multivitamin or any other supplements?

If yes, please list the supplements:

How many times per week do you eat out?

Where do you eat & what do you usually order?

Do you do your own grocery shopping? YES NO

Do you do your own cooking? YES NO

Besides hunger, what other reason(s) do you eat? ❍Boredom ❍Social ❍Stressed ❍Tired ❍Depressed ❍Happy ❍Nervous

Do you eat past the point of fullness? ❍Often ❍Sometimes ❍Rarely ❍Never

What are your "weakness" foods?

Exercise Related Questions:

Fitness History:

On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)?

If your participation is lower than you would like it to be, what are the reasons?

How long have you been consistently physically active?

What activities are you presently involved in:

Cardio &/or Sports:

1-2X/week 3-4X/week 5-6X/week 30 mins 1hr

Example Workout:

Strength Training:

1-2X/week 3-4X/week 5-6X/week 30 mins 1hr

Example workout:

Stretching/Yoga:

1-2X/week 3-4X/week 5-6X/week Length of time:

Other Exercise (Please describe):

1-2X/week 3-4X/week 5-6X/week 30 mins 1hr

What are your goals? How can I best help you? Please check those that apply and/or elaborate further below:

❍Lose body fat ❍Develop muscle tone ❍Rehabilitate an injury ❍Nutrition education ❍Start an exercise program ❍Design a more advanced program ❍Safety ❍Sports-specific training ❍Increase muscle size ❍fun ❍motivation

Other:

Developing your Fitness Program:

1. Realistically, how many days a week would you like to exercise?

3. How much time will you commit to during each exercise session? 30 min 1hr

4. Based on your schedule, how many days will you be in a gym? At home?

5. Based on your commitment, how often would you like to see a trainer to help you achieve your goals?

3x/week 2x/week 1x/week 2x/month 1x/month Other: