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Date:

PERSONAL TRAINER
Intake Form

Please answer the questions in full honesty.
All information on this form is strictly confidential.

1. Personal Information

Name: _____

Address: _____

_____

Birthday: ___ ___ _____

Phone: _____

Email: _____

Sex: M / F

2. Goals

Current health/fitness goals:
Circle what applies, list your top 3 below. Add other goals if needed:

build muscle / body-fat loss / create consistency / decrease stress levels / fun workouts / improve cardiovascular fitness / improve flexibility / improve mood, feel better / improve performance for specific sport / increase energy levels / recover from an injury / nutrition education / reshape or tone body

_____

_____

_____

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3. Health

3.1 Physical Activity Readiness Questionnaire

	Yes	No
Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	☐	☐
Do you feel pain in your chest when you do physical activity?	☐	☐
In the past month, have you had chest pain when you were not doing physical activity?	☐	☐
Do you sometimes lose your balance because of dizziness or do you ever lose consciousness?	☐	☐
Do you have any physical problems (for example, back, knee or hip) that could be made worse by a change in your physical activity?	☐	☐
Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?	☐	☐
Do you know of any other reason why you should not do physical activity?	☐	☐

If you have answered "Yes" to one or more of the above questions, you should consult a physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

3.2 General & Medical Questionnaire

History of pain or injuries: _____

_____

History of hospitalization/surgery: _____

_____

Do you have any diagnosed diseases?_____

_____

Which medications are you currently taking? _____

_____

Are you or have you recently been pregnant? ☐ Yes ☐ No When: _____

Are you or have you recently been smoking? ☐ Yes ☐ No

How long, how much: _____

Are you or have you recently been drinking? ☐ Yes ☐ No

How long, how much: _____

Your stress level from 0 (none) to 10 (max)? _____

How many days per year are you sick? _____

Current practitioner or therapists: _____

Do you suffer from permanent changes due to injury? _____

_____

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4. Current Condition

4.1 Activity Levels

Current fitness level from 1 to 10: _____

Sports & Hobbies: _____

Exertive physical activity per day: _____minutes

Trained in a gym before: ☐ Yes ☐ No Where & when: _____

Weight loss program before: ☐ Yes ☐ No Where & when: _____

Worked with a trainer before: ☐ Yes ☐ No Where & when: _____

Goals & Outcome: _____

4.2 Life & Lifestyle

Occupation: _____ Since: _____

When do you have time to train? Mo ☐ Tu ☐ We ☐ Th ☐ Fr ☐ Sa ☐ So ☐

What time of the day: _____

Self evaluation:

Strength: Low ☐ ☐ ☐ ☐ ☐ High

Endurance: Low ☐ ☐ ☐ ☐ ☐ High

Flexibility: Low ☐ ☐ ☐ ☐ ☐ High

Power: Low ☐ ☐ ☐ ☐ ☐ High

Self-image in one sentence: _____

_____

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4.3 Nutrition

Rate your nutrition: Unhealthy ☐ ☐ ☐ ☐ ☐ Healthy

Describe your regular meals? _____

_____

How often do you cook yourself? _____

Carbs: ☐ Low ☐ Mod ☐ High

Protein: ☐ Low ☐ Mod ☐ High

Fat: ☑ Low ☐ Mod ☐ High

Did you ever track your food intake? ☐ Yes ☐ No

If yes: calories needed/day: _____ calories eating/day: _____

If yes: water intake/day: _____ liters

Which of these are not present in your diet? What else is your diet missing?

whole grains / dairy / lean meats / fruits / vegetables / limited oils

_____

Other comments

_____

_____

_____

_____