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Client Information Questionnaire

Please complete and return to the Front Desk at least 2 days prior to your first scheduled session. All information received on this form will be treated as strictly confidential and will be stored in a locked cabinet. 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 is safe and effective.

General Information

NAME: _____ D.O.B.(MM/DD/YY): _____ AGE: _____
GENDER: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____
HOME/CELL #: _____ WORK #: _____
OCCUPATION: _____ EMAIL: _____

EMERGENCY CONTACT/RELATIONSHIP: _____
EMERGENCT CONTACT PHONE #: _____
PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE: _____

What are your hobbies or interests? _____

_____

How did you hear about us?
- ☐ Website
- ☐ Google
- ☐ Facebook
- ☐ Referral: if so, who? _____
- ☐ Other: _____

General Health Information

Please check if you have had any of the following conditions:

- ☐ Diabetes
- ☐ Asthma
- ☐ Heart Condition or Stroke
- ☐ Epilepsy
- ☐ Hernia
- ☐ Hearing Loss
- ☐ Any chronic illness or medical condition
- ☐ Arthritis
- ☐ Pregnancy
- ☐ Osteoporosis
- ☐ Anemia
- ☐ High/Low Blood Pressure
- ☐ Recent Surgery (in the past 12 months)
- ☐ Any unhealed injury that limits physical ability

Is there a history of any health problems in your family? _____

_____

_____

Do you have pain or have you injured any of the following areas?

- ☐ Neck
- ☐ Shoulder
- ☐ Hip
- ☐ Heel or Foot
- ☐ Ankle
- ☐ Knee
- ☐ Wrist
- ☐ Elbow
- ☐ Upper Back
- ☐ Middle Back
- ☐ Lower Back

When did it happen? _____

Are you currently taking any medication?

Has a health care provider told you that you should avoid certain types of physical acitivity because of your medication intake? ☐ Yes ☐ No

_____

_____

Exercise Background

How many times per week do you partake in cardio exercise? Please check the one that applies. 0 ☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ 7 ☐

Average length (mins):_____
Average intensity: (please check the one that applies) ☐ Easy ☐ Moderate ☐ Hard

How many times per week do you partake in sporting activities?

0 ☐ 1 - 2 ☐ 3 - 4 ☐ 5 - 6 ☐ 7 ☐

Average length (mins):_____
Average intensity: (please check the one that applies) ☐ Easy ☐ Moderate ☐ Hard

Do you train with a heart rate monitor? At what intensity or zone?

_____

What are the main forms of exercise that you enjoy? (Check all that apply).

- ☐ Strength training
- ☐ Walking
- ☐ Running outside
- ☐ Treadmill running
- ☐ Yoga/Pilates
- ☐ Hiking
- ☐ Martial arts
- ☐ Biking outside
- ☐ Stationary biking
- ☐ Elliptical machine
- ☐ Swimming
- ☐ Racquet sports (please specify:)_____
- ☐ Ball sports (please specify:) _____
- ☐ Group classes (if so, please specify:)_____

What are some factors that stop you from exercising?

- ☐ Lack of energy
- ☐ Lack of time
- ☐ I can't afford it
- ☐ Low motivation
- ☐ I don't enjoy it
- ☐ I feel self-conscious
- ☐ Injury (please specify: _____)
- ☐ Other (please specify: _____)

What time of day do you prefer to exercise? Please check the ones that apply.

- ☐ 5-6 AM
- ☐ 6-7 AM
- ☐ 8-10 AM
- ☐ 10-12 PM
- ☐ 12-3 PM
- ☐ 3-5 PM
- ☐ 5-7 PM
- ☐ 7-9 PM

Do you like to train on weekends? ☐ Yes ☐ No

Were you a high school and/or college athlete? ☐ No

☐ Yes What sport? _____

What exercise, sport, or recreational activity/activities have you regularly participated in?

In the past 6 months: _____

In the past 5 years: _____

General Lifestyle Habits

On average, how many hours of sleep do you get per night? _____

In the past 3 months? Please check the ones that apply.

☐ >9 ☐ 7-9 ☐ 6-7 ☐ 5-6 ☐ 4-5 ☐ 3-4 ☐ <3

In the past 2 years? Please check the ones that apply.

☐ >9 ☐ 7-9 ☐ 6-7 ☐ 5-6 ☐ 4-5 ☐ 3-4 ☐ <3

On a scale of 1-5 (1 being poor and 5 being excellent), what would you rate the quality of your diet? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Over the past year, how many days per week have you generally eaten breakfast? (Check the one that applies).

☐ 7 ☐ 5-6 ☐ 4-5 ☐ 3-4 ☐ 2-3 ☐ 1 ☐ 0

How many meals per day do you usually eat? _____

How many servings of fruit and vegetables would you normally eat each day?
(Check the one that applies). ☐ 0-2 ☐ 3-4 ☐ 5+

Describe your job: ☐ Active ☐ Sedentary ☐ Physically Demanding

Does your job require travel? ☐ Yes ☐ No

How do you commute to work? _____
If you bike or walk, how far? _____

Tobacco Use (Check the one that applies).

☐ I currently smoke
☐ I quit smoking less than six months ago
☐ I quit smoking over six months ago
☐ I never used tobacco

Alcohol Use (Check the one that applies).

☐ I frequently drink alcohol
☐ I ocassionally drink alcohol
☐ I seldom drink alcohol
☐ I never drink alcohol

Do you have any children? ☐ No ☐ Yes, how many? _____

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

Have you had a cold or flu in the last year? ☐ No ☐ Yes, how many? _____

What are your 3 biggest sources of stress?

1 _____
2 _____
3 _____

Intentions for Visiting Focus

What are your motivations for training at Focus? Please rate importance on a scale of 1-10, with 10 being the most important.

___ Weight loss:
___ Health:
___ I want more energy:
___ To keep up with kids/family:
___ To meet a performance goal:
___ Enjoyment:
___ To relieve stress:
___ To improve strength:
___ To improve flexibility:
___ To improve stamina:

Please check how you prefer to exercise:

Group Classes: ☐
Semi-Private Training: ☐
Private Training: ☐
Combination: ☐

Here at Focus we offer and encourage clients to take part in a complimentary fitness consultation with one of our personal trainers. The goal of this consultation session is to introduce you to the fitness facility, the services we offer, and our style of training. This is an important opportunity so that you can ensure Focus is the right setting and atmosphere that you need in order to meet your health and fitness goals.

We look forward to meeting you!

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