

Client Profile

Please complete all applicable fields. You can type directly into this form.

Client Information

Contract No.	Date
Name	Name of Gym
Address	Birthday (MM/DD/YYYY)
City	Sex Male Female
State	Occupation
Zip	Body Wt.
Phone (Home)	Body Fat %
Phone (Work)	Height

PERSONAL GOALS

1. Primary Training and Nutrition Objectives (check all that apply):

- | | | |
|-------------|-----------------------|-----------------------------------|
| Fat Loss | Build Muscle | Sport-Specific Training |
| Strength | Shape and Tone | Reduce Stress |
| Weight Loss | Injury Rehabilitation | Increase Cardiovascular Endurance |

2. How serious is your commitment to accomplishing these goals? (1–10):

3. What areas of your body do you specifically want work on:

4. Do you have a specific time frame in mind?

5. Training Experience Sedentary Beginner Intermediate Upper-Intermediate

6. Do you presently engage in physical activity? Yes No

What kind? How often?

7. Are you currently participating in a structured resistance program? Yes No For how long:

8. Are you currently participating in a cardio-respiratory program? Yes No For how long:

9. How often will you work out per week (check one) 3 (minimum) 5 6 7 8 9 10+

10. What kind of cardiovascular activity do you enjoy most? Elliptical Stationary Bike Stationary Rower
Stair Climber Treadmill Aerobics Other

11. Do you have an exact plan to obtain your goals?

12. How long have you been thinking about starting a workout program?

OCCUPATION & LIFESTYLE

1. What is your current occupation?

2. Does your occupation require extended periods of sitting?

3. Does your occupation require extended periods of repetitive movement?

4. How many hours do you work or go to school?

5. If you are a student, specify the subject you are studying:

6. On a scale from 1 to 10, what is your stress level? Personal?

Client Profile

Please complete all applicable fields. You can type directly into this form.

HABITS

1. How many hours of sleep do you get per day? (average)
2. Have you ever suffered from insomnia?
3. How many meals do you eat daily? How many calories?
 Do you eat meat? Yes No Favorite food?
 Do you snack? Yes No Favorite snack?
 Do you have dietary restrictions or allergies? Yes No If yes:
 What? What type?
 Are you currently taking a multivitamin, mineral or other type of food supplement? Yes No
 If yes, what are you taking?
 Why?
4. Do you smoke? Yes No If yes, How Much? Are there any habits you would like to change?
 Do you ingest alcohol? Yes No If yes, How Much?
 Do you drink coffee? Yes No If yes, How Much?
 Would you like to know what supplements would be integral to your success? Yes No

MEDICAL HISTORY

Please check, if applicable, any of the following health problems you have or have diagnosed or treated by a health professional.

- | | | |
|--|---------------------------|-------------------------------|
| Orthopedic Problems | Heart Attack/Stroke | Problems with Balance/Vertigo |
| Heart Murmur | Rheumatic | High Stress |
| Varicose Veins | Loss of Consciousness | Disease of Arteries |
| injuries to back, knees, ankles | Heart Rhythm Abnormality | Hypoglycemia |
| High Blood Pressure | Dizziness | Chest pain of any kind |
| Lung Disease | Epilepsy | High Cholesterol |
| Brain Concussion/Head Injury | Any type of heart problem | |
| Arthritis, what kind? | | |
| Diabetes, how long ago? | | |
| Allergies, (Hay Fever, Asthma) | | |
| Operations, what kind? | | |
| Old or recent injuries? | | |
| When was your last complete physical exam? | | |
| Are you currently taking any medications? Yes No What kind? | | |
| Is there any good reason not mentioned here why you should not follow an activity program even if you wanted to? | | |



Client Profile

Please complete all applicable fields. You can type directly into this form.

FAMILY HISTORY

Have any of your blood relatives (brothers, sisters, parents, grandparents, aunts, uncles, etc.) had:

Heart Attack	High Cholesterol	Other
Heart Operation	Diabetes	
High Blood Pressure	Congenital Heart Disease	

WAIVER

I, the undersigned, have read, understood, and have answered the above health/medical survey questions fully and truthfully. I am aware of my responsibility to consult with my personal physician regarding my medical fitness to engage in strenuous exercise and a nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the participating training facility, and the fitness trainer administering this instrument, for any and all injuries suffered while following the training and/or nutrition program provided to me

Clients Signature

Date

Print Client's Name

Parent/Legal Guardian's Signature*

****If client is under 18 years of age, the parent or legal guardian must sign.***