

CLIENT INFORMATION QUESTIONNAIRE

Please complete and return to us at least 2 days prior to your first scheduled session. All information received on this form will be treated as strictly confidential.

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 interests, and is safe and effective.

First Name: _____ Last Name _____

Date OF Birth ___/___/___

M / D / Y

Address: _____

Street City State Zip Code

Phone: _____ (Primary)

Email address: _____

Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Pulse Fitness will send information regarding your physical exercise program to your physician unless you request otherwise.

Please provide 24 hours notice if you need to cancel or reschedule your Personal Training appointment.

Pulse Fitness

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Scottsdale, AZ 85255

Call us: 480-907-5900

Email us: mytimetobefit@pulsefitnessaz.com

PAR-Q FORM

Please mark YES or No to the following: YES NO

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? _____

Do you frequently have pains in your chest when you perform physical activity? _____

Have you had chest pain when you were not doing physical activity? _____

Do you lose your balance due to dizziness or do you ever lose consciousness? _____

Do you have a 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.)? _____

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

Have you had a recent surgery? _____

If you have marked YES to any of the above, please elaborate below:

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No

What is the medication for? _____

How does this medication affect your ability to exercise or achieve your fitness goals?

Lifestyle Related Questions:

- 1) Do you smoke? YES NO If yes, how many? _____
- 2) Do you drink alcohol? YES NO If yes, how many glasses per week? _____
- 3) How many hours do you regularly sleep at night? _____
- 4) Describe your job: Sedentary Active Physically Demanding
- 5) Does your job require travel? YES NO
- 6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____
- 7) List your 3 biggest sources of stress:
a. _____ b. _____ c. _____
- 8) Is anyone in your family overweight? Mother Father Sibling Grandparent
- 9) Were you overweight as a child? YES NO If yes, at what age(s)? _____

Fitness History:

- 1) When were you in the best shape of your life? _____
- 2) Have you been exercising consistently for the past 3 months? YES NO
- 3) When did you first start thinking about getting in shape? _____
- 4) What if anything stopped you in the past? _____
- 5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)? _____

Nutrition Related Questions

- 1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? _____
- 2) How many times a day do you usually eat (including snacks)? _____
- 3) Do you skip meals? YES NO 4) Do you eat breakfast? YES NO
- 5) Do you eat late at night? Sometimes Often Never
- 6) What activities do you engage in while eating? (TV, reading etc) _____
- 7) How many glasses of water do you consume daily? _____
- 8) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N

If yes, please list the supplements:

9) List 3 areas of your Nutrition you would like to improve:

3

a. _____ b. _____ c. _____

Exercise Related Questions:

Skip to next section if you are presently inactive.

1) How often do you take part in physical exercise?

5-7x/week 3-4x/week 1-2x/week

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

Lack of Interest Illness/Injury Lack of Time

Other _____

3) How long have you been consistently physically active for? _____

4) What activities are you presently involved in?

Cardio &/or Sports

Frequency/Week Average Length Easy/Mod/Hard

Strength Training

Frequency/Week Average Length Easy/Mod/Hard

List exercises: _____

Flexibility Frequency/Week Average Length

If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY SUNDAY

Goal Setting:

How can a Personal Trainer help you? Please check that which applies.

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 _____

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

S= Specific (Provide details, how long, how much etc.)

M= Measurable (How will you measure whether you've reached your goals)

A= Attainable (Be realistic, set smaller goals)

R = Rewards-Based (Attach a reward to each goal)

T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

a) _____

b) _____

c) _____

2. How will you feel once you've achieved these goals? Be specific.

3. Where do you rate health in your life? Low priority Medium Priority High priority

4. How committed are you to achieving your fitness goals? Very Semi Not very

5. What do you think the most important thing we can do to help you achieve your fitness goals?

6. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc.).

7. Outline 3 methods that you plan to use to overcome these obstacles:

a. _____ b. _____ c. _____

Miscellaneous Questions:

1. How did you hear about us? Please check that which applies.

Brochure Word of Mouth Yellow Pages Website

Other _____

2. If you were referred to us, who told you about our services?

3. Why did you choose to train with Pulse Fitness instead of another organization? Please check that which applies.

Location Personal Trainers Cost Customer Service Word of Mouth Programs

Other _____

4. How far do you live from our gym? _____ miles

5. Which newspaper(s) do you read? _____

6. Which radio station(s) do you listen to? _____

7. Which local magazine(s) do you read? _____

8. Which local morning TV show do you watch? _____

9. What would cause you to discontinue training with Pulse Fitness?

CLIENT

PERSONAL TRAINER

DATE

DATE