

Original Date:
Dates Revised:

FITNESS TRAINING QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Address:		
Home Number:	Work Number:	
Mobile Number:	Email Address:	
Occupation:	How many hours do you work a week:	
Emergency Contact:		

FITNESS HISTORY

Current Weight:		
How long at this weight:		
Height:		
Have you ever had a PT before? (what did you like most and least about them)		
List what you would like to accomplish through your fitness program with me:		
1		
2		
3		
4		
5		
6		

What type of motivation do you require and expect from a trainer?		
1		
2		
3		
4		
5		
6		

Do you own any type of exercise equipment? (Please list below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Current Leisure Activities:		
How long at this weight:		
Height:		
Have you ever had a PT before? (what did you like most and least about them)		
List what you would like to accomplish through your fitness program with me:		
1		
2		
3		
4		
5		
6		

FITNESS HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 mins.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	# of meals you eat in an average day?			
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you considered stopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you drive after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
<input type="checkbox"/> # of years		<input type="checkbox"/> Or year quit		
	Do you start exercise programs but then find yourself unable to stick to them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	How much time are you willing to devote to an exercise program?	Week/Days Minute/day		

Exercise Commitments	How long have you been exercising?	Month/Years	
	What other exercise, sports or recreational activities have you participated in?		
	Can you exercise during your work day?		<input type="checkbox"/> Yes
What types of exercise interests you?			
<ul style="list-style-type: none"> - Walking(Treadmill/Outdoors) - Running (Treadmill /Outdoors) - Hiking - Swimming - Tennis - Golf - Cycling - Stationary Bike - Spin - Rowing - Strength/Weight Training - Softball - Tai Chi - Yoga - Stretching - Pilates - Dance Exercise 			
Anything else I should know about?			

FITNESS TEST

AEROBIC ENDURANCE TEST

- Run/walk as far as you can in nine minutes
- Run/walk one mile as fast as you can

FLEXIBILITY TEST

- stretch

STRENGTH TEST

- Sit ups - number of sit ups in 60seconds
- Pull ups - number of pull ups in 60 seconds
- Push ups – number of push up in 60 seconds

BODY COMPOSITION TEST

- Weight
 - Chest - inches
 - Waist – inches
 - Hips - Inches
 - Wrist – inches
 - Forearm - Inches
-

PROGRAM

Beginning Date:	
End Date:	
Warm up Activities:	
Intensity Activities:	
Sessions per week:	
Time Per Session:	
Equipment needed:	
Facilities needed:	
Exercise Buddy?	

Test Results	Initial	Week 2	Week 4	Week 6	Week 8	Week 10	Week 12	Change
Dates:								
9 Min run/walk								
1 mile run/walk								
Flexibility Reach								
Sit ups in 60Sec								
Pull ups								
Push Ups								

Measurements:	Initial	Week 12	Change	Comments
Chest				
Waist				
Hips				
Forearm				