



**Personal Training
Studio**

Client Information

Name: _____

Height: _____ Weight: _____

Please mark each statement that is true.

____ You are a man over the age of 45 years.

____ You are a woman over the age of 55 years.

____ You presently smoke or have quit within the past 6 months.

____ You have high blood pressure or take blood pressure medication.

____ Systolic blood pressure over 140mmHg

____ Diastolic blood pressure over 90mmHg

____ You have been told you have high cholesterol

____ Your father or brother had a heart attack or heart surgery before the age of 55.

____ Your mother or sister had a heart attack or heart surgery before the age of 55.

Exercise Habits

____ Intensive occupational and recreational exertion

____ Moderate occupational and recreational exertion

____ Sedentary occupational and recreational exertion

____ Sedentary work and moderate recreational exertion

____ Sedentary work and light recreational exertion

____ Complete lack of occupational or recreational exertion

Is there any reason why you can't exercise regularly? _____

What exercises do you enjoy or have enjoyed in the past? _____

Existing Medical Conditions (Please check)

____ Anemia

____ Epilepsy

____ Pregnancy

____ Arthritis

____ Heart Condition

____ Thyroid Problem

____ Asthma

____ Hernia

____ Ulcer

____ Cholesterol

____ Obesity

____ Other: _____

____ Diabetes

Are you taking any medications? ☐ Yes ☐ No

If yes, please list and indicate if medication is required.

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Medication: _____ Condition: _____

Allergies

Do you have any allergies? ☐ Yes ☐ No

If yes, please list and indicate if medication is required.

Allergy: _____ Condition: _____

Allergy: _____ Condition: _____

Injuries

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

____ Hip: R L Shoulder: R L

____ Knee: R L Elbows: R L

____ Ankle: R L Wrists: R L

____ Neck

____ Upper back

____ Lower back

Please explain:

Contact In Case of Emergency

Name: _____

Phone Number: _____

Relation: _____

Family Physician

Name: _____

City: _____

Phone Number: _____

Lifestyle

	Always	Sometimes	Never
I get 7-8 hours of sleep per night	_____	_____	_____
I am physically active 3x week	_____	_____	_____
I have regular medical checkups	_____	_____	_____
I eat 3-5 servings of vegetables per week	_____	_____	_____
I eat 2-4 servings of fruit per week	_____	_____	_____
I eat 6-10 servings of grains and cereals per week	_____	_____	_____
I eat 2-3 servings of meat and nuts per week	_____	_____	_____
I make a conscious effort to eat healthy	_____	_____	_____
I follow a strict diet	_____	_____	_____
I am a very happy person	_____	_____	_____
I am a motivated person	_____	_____	_____

Comments: _____

Personal Trainer

By signing this form, I certify that I have asked for and understand the pertinent information required for me to make an informed decision.

Signature _____ Date: _____

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