

Client Profile Questionnaire

Date ___/___/___

Name _____

Gender: ___Male ___Female

Birth Date ___/___/___

Age _____

Weight _____

Height _____

Spouse's Name _____

Number of Children _____

Names/Ages of children _____

Address _____

City _____

State _____

Zip _____

Home Phone (____) _____ - _____

Work Phone (____) _____ - _____

Mobile Phone (____) _____ - _____

Pager (____) _____ - _____

Email1 _____

Email2 _____

Occupation/Type of Work _____ Company _____

What type of hours do you put in? _____

Did someone refer you? ___Yes ___No Who? _____

What is the activity level of your day (not including exercise)? ___Light ___Moderate ___Heavy

How would you describe your overall daily energy level?

___Very Low ___Low ___Medium ___High ___Very High

What are your primary health and fitness goals? (Please define as specifically as possible with deadlines)

1. _____

2. _____

3. _____

What has prevented you from reaching these goals in the past?

What components do you feel that you need help with? (Please check all that apply)

___Exercise Instruction ___Program Design ___Nutrition ___Accountability

___Mobility ___Flexibility ___Posture ___Strength/Conditioning

How many days per week are you willing to REALISTICALLY commit to an exercise program? _____

What days could you potentially schedule workouts? (Please check all that apply)

M T W Th F Sa

How much time per workout? _____

What time(s) of the day would you be able to workout? (Please check all that apply)

Early Morning Late Morning Lunchtime Afternoon Evening

Please list any exercise equipment you have at your home.

Please list any sports/recreational activities you participate in, and how often.

Current Exercise Program—Resistance Training

How many days per week are you currently resistance training? _____ Where? _____

Current Exercise Program—Aerobic/Cardiovascular Training

How many days per week are you currently doing aerobic exercise? _____ Where? _____

What meals/snacks do you normally eat during the day?

(Please list typical food choices)

Breakfast _____

Mid-morning _____

Lunch _____

Afternoon _____

Dinner _____

Evening _____

How much coffee, tea, or soda do you drink during the day? _____

How much water do you drink during the day? _____

How much sleep do you get per night? _____

What is your stress level? Low Moderate High

What is your personality type? Laid Back Aggressive Moody Hot Tempered

Please list all medications you take.

Please list any nutritional supplements that you use regularly.

Please list any injuries, diseases, illnesses or other limitations that may require special attention.

What is your favorite restaurant? _____

What is your favorite color? _____

What is your favorite band/musical group? _____

What type of books do you enjoy reading? _____

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate profile.

Client's signature

Date

CONFIDENTIALITY NOTICE: The information recorded within this document will remain confidential to all parties involved.