Spectrum Strength Training

Client Intake Form

All information received on this form will be kept confidential. Please fill out completely and accurately.

Name: _____Date of Birth: _____ Age: _____

Address:_____

Phone: _____ Email: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Physicians Name: _____ Phone: _____

Health

All information received on this form will be kept confidential. Please fill out completely and accurately.

PAR-Q Form: Please mark **YES or NO** to the following:

1) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? ___

2) Do you feel pain in your chest when you do physical activity? ___

3) In the past month, have you had chest pain when you were not doing physical activity? ___

4) Do you lose your balance because of dizziness or do you ever lose consciousness? ___

5) 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)? ___

6) Are you pregnant now or have given birth within the last six months? ___

7) Have you had a recent surgery? ___

8) Do you take any medications, either prescription or non-prescription, on a regular basis? ___

- What is the medication for? _____

9) Do you know of any other reason why you should not do physical activity? ___

- If you marked **yes to any of the above**, please explain below:

_____

_____

Health: Lifestyle

All information received on this form will be kept confidential. Please fill out completely and accurately.

Do you smoke? **Yes** **No** If yes, how many per day? _____

Do you drink alcohol? **Yes** **No** If yes, how much per week? _____

How many hours do you regularly sleep at night? _____

Describe your job: **Sedentary** **Active** **Physically Demanding**

Does your job require you to travel? **Yes** **No**

On a scale from 1-10, how would you rate your stress level? (1=low, 10=high): _____

List your **3** biggest sources of stress

a. _____ b. _____ c. _____

Do you regularly use the services of a massage therapist? **Yes** **No** Chiropractor? **Yes** **No**

Were you overweight as a child? _____

Developing Your Fitness Program

All information received on this form will be kept confidential. Please fill out completely and accurately.

How often do you take part in physical exercise? _____ per week _____ duration
If your participation is lower than you would like it to be, what are the reasons? Circle

Lack of interest **Illness/Injury** **Lack of Time** **Other**: _____

What activities are you presently involved in? **Please briefly describe intensity and frequency**

- Cardio / Movement _____
- Strength Training / Pilates _____
- Stretching / Yoga _____
- Sports and/or outdoor activities _____
- Other _____

Which area(s) would you like the most assistance with?

_____

How do you learn best? **Visual** **Auditory** **Combination**

Schedule

All information received on this form will be kept confidential. Please fill out completely and accurately.

Realistically, how often would you like to exercise? _____ per week

Realistically, how much time would you like to spend during each exercise session? _____mins

Based on your commitment, how often would you like to see a trainer to help you achieve your goals? **Please circle one.**

3x/week 2x/week 1x/week 2x/month 1x/month

What are the best days during the week for you to commit to your exercise program?

M T W Th F Sat Sun

What are the best times for you to exercise? **Circle all that apply.**

Morning Afternoon Evening

Goal Setting

All information received on this form will be kept confidential. Please fill out completely and accurately.

What made you decide to do personal training?

_____

What is your primary goal?

_____

What are your favorite activities?

_____

On a scale of 1-10, how would you rate your current fitness level (1=worst, 10=best)? _____

How can we help you? **Please circle all that apply:**

Lose Body Fat Develop Muscle Tone Reduce Stress Rehabilitate an Injury

Nutrition Education Start an Exercise Program Design a More Advanced Program

Sports Specific Training Motivation Fun Training for an Event

Other _____

Realistically, when would you like to achieve your goals? _____

How important is it for you to achieve these goals?

Not important **Semi-important** **Very important**

How long have you been thinking about these goals? _____

How will you feel once you have achieved these goals? _____

Where do you rate health in your life?

Unhealthy **Average** **Good**

Where does your spouse/significant other/family rate health in their lives?

Unhealthy **Average** **Good**

What do you think is the most important thing your trainer can do to help you achieve these goals?_____

_____

List what you feel are the obstacles or potential actions, behaviors or activities that could impede your progress towards accomplishing your goals?

_____

_____

List three methods that you plan to use to overcome these obstacles

a. _____ b. _____ c. _____

Nutrition

All information received on this form will be kept confidential. Please fill out completely and accurately.

On a scale from 1-5, how would you rate your nutrition (1=poor, 5=excellent)? _____

How many times throughout the day you eat? _____

Do you skip meals? **Yes** **No** Do you eat breakfast? **Yes** **No**

Do you eat late at night? **Yes** **No**

What activities do you engage in while eating (TV, reading, etc)? _____

How many glasses of water do you consume daily? _____

Do you have decreased energy throughout the day or changes in mood? **Yes** **No**

What kinds of food do you regularly eat?

_____

Do you know how many calories you consume in a day? **Yes** **No**

-If yes, how many? _____

Have you ever tracked your food intake (i.e. food diary)? **Yes** **No**

Are you currently taking a multivitamin or any other supplements? **Yes** **No**

How often do you eat out on a weekly basis? _____

Do you do your own cooking? **Yes** **No**

Do you do your own grocery shopping? **Yes** **No**

Besides hunger, are there any other reasons you eat? Circle those that apply if any.

Bored **Social** **Stressed** **Tired** **Depressed** **Happy** **Nervous**

Do you eat mostly processed food or freshly prepared food? **Processed** **Fresh**

Do you eat past the point of fullness? **Yes** **No**

Do you read nutrition labels? **Yes** **No**

- If so, what do you look at? _____

List three areas that you would like to improve in the nutrition area:

a. _____ b. _____ c. _____

Miscellaneous

All information received on this form will be kept confidential. Please fill out completely and accurately.

Please list anything else that you may feel is a concern or information that has not been disclosed that may be pertinent to being physically active or working with a personal trainer.

_____

_____

Thank you so much for taking the time to fill out our client intake form and we look forward to working with you!

Spectrum Strength Training