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Client Information Form

Please complete and return to the reception desk at least 2 days prior to your first scheduled session.

The information on this form is confidential and will be used for no other purpose than for Focus Personal Fitness records.

CONTACT INFO

Name: _____ **Date:** _____

Date of Birth: **Age:** _____

Address:

Home Telephone: _____ **Mobile:** _____

Business Telephone: _____ **Email:** _____

EMERGENCY CONTACT INFO

Emergency Contact 1: _____ **Telephone:** _____

Emergency Contact 2: _____ **Telephone:** _____

Physician's Name: _____ **Telephone:** _____

PHYSICAL ACTIVITY

Have you ever followed an exercise program before? ☐ YES ☐ NO

If NO: What has stopped you from exercising?

- ☐ Lack of interest/injury
- ☐ Lack of time

If YES: How often do you take part in physical exercise?

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

CARDIO:

- ◯ Easy
- ◯ Moderate
- ◯ Hard

Frequency/week:

Average length:

SPORTS:

- ◯ Easy
- ◯ Moderate
- ◯ Hard

Frequency/week:

Average length:

LIST EXERCISES:

Stretching: ☐ YES ☐ NO

Strength Training: ☐ YES ☐ NO

Have you ever used a Personal Trainer before? ☐ YES ☐ NO

Tell us about your experience with personal training

(e.g. How many sessions per week? Did you feel you made progress toward your goals? What did you like best about training? What did you like least?)

Please tell us how you prefer to exercise:

- ☐ Large Groups
- ☐ Small Groups
- ☐ Alone
- ☐ Combination

- ☐ Inside
- ☐ Outside
- ☐ Combination

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

Realistically, how often a week would you like to exercise?

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

Please indicate the best days and times for you to exercise with a trainer?

Day: Time:

HEALTH INFO

Do you smoke? ☐ YES ☐ NO

If yes, how many per day?

Do you drink alcohol? ☐ YES ☐ NO

If yes, how many glasses per week?

How many hours do you regularly sleep at night?

Describe your job:

- ◯ Sedentary
- ◯ Active
- ◯ Physically demanding

Does your job require travel?

- ◯ YES
- ◯ NO

On a scale of 1-10, how would you rate your stress level? (1 = very low, 10 = very high) Select

List your 3 biggest sources of stress:

Please check if you have or have had any of the following conditions:

- ☐ Diabetes
- ☐ Asthma
- ☐ Heart Condition or Stroke
- ☐ Epilepsy
- ☐ Hernia
- ☐ Hearing Loss
- ☐ Any chronic illness or medical condition
- ☐ Pregnancy
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Anemia
- ☐ High/Low Blood Pressure
- ☐ Recent surgery (In the past 12 months)
- ☐ Any unhealed injury that limits physical ability

Is there a history of any health problems in your family?

Are there any other medical conditions not listed above that could affect or limit your ability to exercises, or could cause a fitness program to be potentially dangerous for you? If so, please explain.

Do you have pain or have you injured any of the following areas:

- ☐ Neck
- ☐ Shoulder
- ☐ Hip
- ☐ Heel or Foot
- ☐ Ankle
- ☐ Knee
- ☐ Wrist
- ☐ Elbow
- ☐ Upper Back
- ☐ Middle Back
- ☐ Lower Back

When did it happen?

Are you currently taking any medications? ☐ **YES** ☐ **NO**

If you checked YES, please list the medication and for what condition.

NUTRITION INFO

How would you rate your knowledge of nutrition?

- ◯ Need Help
- ◯ Adequate
- ◯ Advanced

How many times a day do you usually eat? (including snacks)

Do you skip meals?

- ◯ **YES**
- ◯ **NO**

Do you eat breakfast?

- **YES** ◯
- **NO** ◯

Do you eat late at night?

- Often ◯
- Sometimes ◯
- Never ◯

How many glasses of water do you consume daily?

Do you feel drops in your energy levels throughout the day? ☐ YES ☐ NO

If yes, when?

At work or school, do you usually:

- ☐ Eat out
- ☐ Bring food

Do you do your own grocery shopping?

- ◯ YES
- ◯ NO

Do you do your own cooking?

- ◯ YES
- ◯ NO

Besides hunger, what other reason(s) do you eat?

Do you eat past the point of fullness?

- ◯ Often
- ◯ Sometimes
- ◯ Never

Do you eat foods high in fat and sugar?

- ◯ Often
- ◯ Sometimes
- ◯ Never

How often do you eat out?

Breakfast: Lunch: Dinner:

Do you take a multi-vitamin/mineral?

- ◯ YES
- ◯ NO

Do you use any other nutritional supplements?

- ◯ YES
- ◯ NO

If yes, what do you use and why?

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