YOGA DUDE
FITNESS

PERSONAL TRAINING CLIENT INTAKE FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Physicians Name: _____ Phone: _____

Please allow 24 hours notice if you need to cancel or reschedule your appointment.

Personal Info

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)? _____

Health ~ PAR-Q Form **Please mark YES or NO to the following:**	**YES**	**NO**
- Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	___	___
- Do you feel pain in your chest when you do physical activity?	___	___
- In the past month, have you had chest pain when you were not doing physical activity?	___	___
- Do you lose your balance because of dizziness or do you ever lose consciousness?	___	___
- 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 aliments, back problems, etc)?	___	___
- Are you pregnant now or have given birth within the last six months?	___	___
- Have you had a recent surgery?	___	___
- Do you take any medications, either prescription or non-prescription, on a regular basis?	___	___
- What is the medication for? _____		
- 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:

_____

_____

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

CLIENT INTAKE FORM

Lifestyle Related

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

Is anyone in your family overweight? _____

Were you overweight as a child? _____

Developing Your Fitness Program

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?

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

What activities are you presently involved in?

Cardio / Movement _____

Strength Training / Pilates _____

Stretching / Yoga _____

Sports and/or outdoor activities _____

Other _____

Which area would you like the most assistance with? _____

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

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

Based on your commitment, how often would you like to see a trainer to help you achieve your goals?

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? Morning Afternoon Evening

If you could design your own exercise program, what would an ideal training week look like? Be specific.

_____

_____

CLIENT INTAKE FORM

What would you ultimately like to learn from a trainer/these sessions?

_____

_____

Goal Setting

How can I 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 _____

In order to increase your chances of being successful at achieving your goals, ensure your goals are "SMART"

S=Specific (provide details, how much, how long, etc)
M=Measurable (how will you measure when you've reached your goals)
A=Attainable (be realistic, set smaller goals)
R=Rewards-based (attach a reward to each goal)
T=Time (set specific dates for goals)

Please list in order of priority, the goals you would like to achieve in the next 3-12 months:

a. _____

b. _____

c. _____

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. _____

CLIENT INTAKE FORM

Nutrition

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 every tracked your food intake (i.e. food diary)? Yes No

Are you currently taking a multi-vitamin 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, what other reasons do you eat?

Bored Social Stressed Tired Depressed Happy Nervous

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

Do you eat foods high in fat and sugar? Yes No

Do you eat past the point of fullness? Yes No Do you prefer salty or sugary foods? Salty Sugary

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

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.

_____

_____

_____