Client Profile & Consultation Form

Today's date: _____

Client information

Client Name: _____ Date of Birth: _____

Address: _____

City: _____ Prov: _____ P.C.: _____

Phone: _____ Email: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Physical Activity Readiness Questionnaire (PAR-Q+ from CSEP)

1. Has your doctor ever said that you have a heart condition OR high blood pressure? YES / NO
2. Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity? YES / NO
3. Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise). YES / NO
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? YES / NO
5. Are you currently taking prescribed medications for a chronic medical condition? YES / NO
6. Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other. YES / NO
7. Has your doctor ever said that you should only do medically supervised physical activity? YES / NO

If you answered NO to all of the questions above, you are cleared for physical activity.

If you answered YES to any of these questions, you'll need to fill out a more detailed form. If you are ill (such as a cold), wait until you are better before becoming much more active.

Medications and supplements

Do you have any other health concerns or medical issues that may impact the type of physical activities you can do and that your Trainer needs to be aware of? YES / NO
Please explain:

Are you taking:

Medications? Please list:

Supplements? Please list:

Physician information

If you are seeing a physician for a medical condition that might be affected by fitness training, please complete:

Physician name: _____

Phone: _____ Fax: _____

Do you have a personal release to contact / fax the physician? YES / NO

Notes:

Client readiness

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction. If my health status changes, I will let the Trainer know.

Name: _____

Signature: _____ Date: _____

Client consultation

Goals and expectations

What are your expectations in regards to fitness training?

What are your goals?

Have you tried to achieve these or similar goals before? Explain:

Why are your goals important to you?

How will you know when you have reached your goal? Be specific:

How will you feel once you have achieved these goals?

Are there any major behaviors that you wish to change? (such as eating habits)

Do you have any priorities for your expectations?

How committed are you to achieving your goals right now? Scale of 1–10.

Do you have any performance or sport-specific expectation?

Physical activity

Describe your current exercise habits:

Secondary exercise questions:

- How often do you take part in physical exercise?
  - 5–7/week; 3–4/week; 1–2/week; None
- What activities / exercises are you currently doing?
- If your participation is lower than you would like, what are the reasons?
- What exercise activities interest you?
- How many days a week would you like to workout?
- What time of the day is best for you to workout?
- What days are best for you to workout?
- What type of equipment do you prefer?
- What type of equipment do you own/have for your use?
- What types of exercise do you dislike or want to avoid?

Dietary habits

How much do you know about nutrition and healthy eating?

Describe your general dietary (eating) habits:

Secondary dietary questions:

- How many times a day do you usually eat (including snacks)?
- Do you skip meals? YES / NO
- Do you eat breakfast? YES / NO
  - Within 1 hour of waking? YES / NO
- Do you eat late at night? YES / NO
- How many glasses of water do you drink daily?
- How many times a day/week do you eat out?
- Do you do your own grocery shopping?
- Do you do your own cooking?
- Besides hunger, what other reasons do you eat?
  - Boredom, Social, Stress, Tired, Depressed, Happy, Nervous, Other_____

Are you interested in resources or learning more about healthy eating and nutrition? YES / NO

More life questions

What are your energy levels during the day? Scale of 1–10.

How many times were you sick in the last year?

How many hours of sleep do you get a night, on average?

What is the quality of your sleep?

Are you under a lot of stress? Is the stress work related or personal?

Do you smoke? YES / NO

Do you drink alcohol? YES / NO

That's it. We'll discuss this in your assessment.