

Force Physiques Fitness Questionnaire

Personal Information

Name: _____

DOB: _____ Gender: M / F Married / Single (circle one)

Address: _____

Home/Cell Number: _____ Email Address: _____

Emergency Contact (name and phone number): _____

Occupation: _____ Work Number: _____

How many hours a week do you work? _____

Sport and Exercise History and Information

What sports or recreational activities do you or have you participate(d) in? _____

Have you had a personal trainer before? Y / N If so, when and where? _____

What did you like least? _____

What did you like most? _____

Describe your current exercise program _____

What type of exercise(s) interest you?

Walking ___ Jogging/Running ___ Strength Training ___ Boot Camps ___ Yoga ___ Dance ___

Kickboxing ___ Step Aerobics ___ Other activities _____

Rate your overall health status:

Excellent ___ Good ___ Average ___ Poor ___

Rate your overall fitness status:

Excellent ___ Good ___ Average ___ Poor ___

Present height _____ Present weight _____

What are your personal goals? _____

What would like to accomplish through training with me? _____

What do you expect from me as your trainer? _____

Medical History

Have you had a complete physical, including blood work, in the past year? Yes / No

Are you taking any medications? If so, what? _____

Do you have now, or have any history of, the following:

- | | |
|--|----------|
| 1. Cardiovascular Disease | Yes / No |
| 2. Chest pain | Yes / No |
| 3. Stroke | Yes / No |
| 4. High blood pressure | Yes / No |
| 5. Elevated cholesterol | Yes / No |
| 6. Diabetes | Yes / No |
| 7. Fainting/dizziness | Yes / No |
| 8. Asthma or breathing difficulties | Yes / No |
| 9. Smoker | Yes / No |
| 10. Joint pain/injury | Yes / No |
| 11. Hernia and/or muscle pain/injury | Yes / No |
| 12. Arthritis | Yes / No |
| 13. Recent surgery (past 12 months) | Yes / No |
| 14. Recent hospitalization (past 12 months) | Yes / No |
| 15. Pregnancy (now or within the last 3 months) | Yes / No |
| 16. Advice from a physician to not exercise | Yes / No |
| 17. Other symptom(s) that may be of concern | Yes / No |
| 18. Alcohol use | Yes / No |

If so, please explain _____

Is there anything else I should know about you? _____

Participant Signature

Date

The information provided here will be kept confidential and will be released to you upon completion of the session, or shredded at your request.
Christy Bowers, CI-CPT*Force Physiques*, President

Comments and Notes:

Body Measurements:

Right arm circumference _____

Left arm circumference _____

Chest circumference _____

Waist circumference _____

Hip circumference _____

Right thigh circumference _____

Left thigh circumference _____

Current weight _____

BMI _____ (if desired)

Resting BP _____

Risk Factors –

BP _____

WT _____

Chol _____

Ex _____

Smok _____

Str _____

Diab _____

Age _____

GEN _____

FHis _____

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