

PERSONAL TRAINING QUESTIONNAIRE

I. GENERAL INFORMATION

Date: _____

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Primary Physician: _____ Phone: _____

Explain what is motivating you at this time in your life to reach and maintain a fit and healthy lifestyle: _____

Weight: _____ Has your weight changed in the last 6 months? **Yes** **No** If yes, how has it changed? _____

What would you like to weigh? _____ Occupation: _____ Work Stress: **Low** ____, **Medium** ____, **High** ____
Energy Level: **Low** ____, **Medium** ____, **High** ____ How do you spend most of your time at work? **Sitting** ____, **Standing** ____,
Carrying Loads ____, **Driving** ____, **Walking** ____ Diagnosis: _____

Chief Complaint: _____ Date of Onset: _____ Are you currently off of work due to health issues? **Yes** **No** If yes, explain: _____

Do you have or have you had any of the following: (Place a check mark or circle as appropriate.)

- | | | | | | |
|--------------------------------------|------------|-----------|---|------------|-----------|
| 1) High Blood Pressure | Yes | No | 11) Broken Bones of Back or Neck | Yes | No |
| 2) Heart Disease or Heart Attack | Yes | No | 12) Back Problems | Yes | No |
| a) Chest Pain or Angina | Yes | No | 13) Muscle Problems or Disease | Yes | No |
| b) Irregular Heart Beat | Yes | No | 14) Unexplained Fevers | Yes | No |
| c) Congestive Heart Failure | Yes | No | 15) Psych./Emotional Problems | Yes | No |
| d) Abnormal EKG | Yes | No | 16) Loss or Thinning of Hair | Yes | No |
| 3) Gastric Esophageal Reflux (GERD) | Yes | No | 17) Skin: Dry ____, Oily ____, Bruising ____, Acne ____,
Other: _____ | | |
| 4) Recent Cold, Cough or Sore Throat | Yes | No | 18) Fatigued Most of the Day | Yes | No |
| 5) Asthma, Emphysema, Bronchitis | Yes | No | 19) Feel Cold Most of the Day | Yes | No |
| 6) Diabetes | Yes | No | 20) Balance Problems | Yes | No |
| 7) Kidney Disease | Yes | No | 21) Female Problems: Cramps ____, PMS ____, Conception ____,
Exercise? | Yes | No |
| 8) Stroke or TIAs | Yes | No | 22) Difficulty Losing Wt., Even With Low Calories &
Exercise? | Yes | No |
| 9) Numbness, Tingling or Weakness | Yes | No | | | |
| 10) Epilepsy or Convulsive Seizures | Yes | No | | | |

Do you have any allergies to medication? **Yes** **No** **If yes, what:** _____

Do you have any allergies to food? **Yes** **No** **If yes, what:** _____

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

Are you pregnant? **Yes** **No**

Hours of sleep per night? _____ Hours; Bed Time: _____ AM/PM; Time You Awake: _____ AM/PM

How many times do you get up during the night? _____ Why? _____

Drugs & Medication: List all medications & the dosage (including vitamins, minerals, herbal & over the counter drugs).

Musculoskeletal Information: Please describe any past or current conditions you have incurred such as muscle pulls, sprains, fractures, surgery, back pain, or general discomfort:

Head/Neck: _____ Hip/Pelvis: _____

Upper Back: _____ Thigh/Knee: _____

Shoulder/Clavicle: _____ Arthritis: _____

Arm/Elbow: _____ Hernia: _____

Wrist/Hand: _____ Surgeries: _____

Lower Back: _____ Other: _____

Physical Activity

Is there any reason why you should not follow a physical activity program, even if you wanted to? _____

Do you find it difficult to perform vigorous exercise? _____

Have you recently experienced any chest pain associated with either exercise or stress? **Yes** **No**

If yes, explain: _____

Recreational Activities: _____

Work Activities: _____

Type of Exercise

- Circle One:** **None** = Do not currently exercise
Mild = Exercise 1-2 days per week; _____ minutes/ session _____
Moderate = Exercise 3-4 days per week; _____ minutes/ session _____
High = Exercise 5-7 days per week; _____ minutes/ session _____

What activities would you prefer in a regular exercise program? ___Swimming ___Bicycling (outdoors) ___Tennis
___Bicycling (indoors) ___Walking or Running ___Stationary Walking or Running ___Jumping Rope
___Hand or Racket Ball ___Basketball ___Others: _____

