OPERATOR FITNESS, LLC.

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

Client Info:

Name: ____________________________________ Date of Birth: ____________ Age: _____

Address: ____

Phone: __________________________ Email: ______________________________________

Occupation: ____

Emergency Contact: ________________________________ Phone: ____________________

Relationship: ____

Physicians Name: _______________________________ Phone: _______________________

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 ***<u>Please mark YES or NO to the following:</u>***

Has your doctor ever said that you have a heart condition and that you should only perform

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, et cetera)? _______

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:

____
____
____
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____

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?
a.________ times per week
b. __________ minutes in 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? _______________ times per week

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

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

3xweek *2xweek* *1xweek* *2xmonth* *1xmonth*

What are the best days during the week for you to commit to your exercise program?

Sunday *Monday* *Tuesday* *Wednesday* *Thursday* *Friday* *Saturday*

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.

____
____
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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. ____

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 8 ounce 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.

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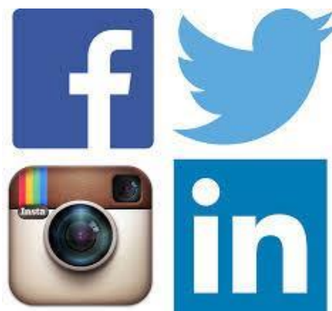
THE BEST COMPLIMENT WE CAN RECEIVE IS YOUR REFERAL OF ANOTHER POTENTIAL CLIENT!



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