Yvette Salva Fitness

See Results. Feel the difference.

CLIENT HEALTH QUESTIONAIRE

Please print, complete and return at your first scheduled session.

All information received on this form will be treated as strictly confidential.

Please fill out the forms ***completely and accurately***. This information is essential to helping your trainer develop a program that addresses your needs, goals, and is safe and effective.

Name:_____ Date of Birth____/____/____ Age:_____
M D Y

Address:_____
Street City State Zip Code

Phone: _____(h) _____(o) _____(fax)

Email address: _____

Occupation:_____

Emergency Contact: _____ Relationship: _____

Phone Number:_____

Physician's Name:_____ Physician's Phone:_____

Physician's Address:_____
Street City State Zip Code

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

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 recommended only medically supervised physical activity?	____	____
Do you frequently have pains in your chest when you perform physical activity?	____	____
Have you had chest pain when you were not doing physical activity?	____	____
Do you lose your balance due to 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 ailments, back problems, etc.)?	____	____
Are you pregnant now or have given birth within the last 6 months?	____	____
Have you had a recent surgery?	____	____

If you have marked YES to any of the above, please elaborate below:

_____
_____
_____
_____

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No

What is the medication for?_____

How does this medication affect your ability to exercise or achieve your fitness goals?

_____
_____

Lifestyle Related Questions:

1) Do you smoke? YES NO If yes, how many per day?_____

2) Do you drink alcohol?YES NO If yes, how many glasses per week?_____

3) How many hours do you regularly sleep at night? _____

4) Describe your job: ❍ Sedentary ❍ Active ❍ Physically Demanding

5) Does your job require travel? YES NO

6) On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)? _____

7) List your 3 biggest sources of stress:
a. _____ b. _____ c. _____

8) Do you regularly utilize the services of a massage therapist? YES NO

9) Is anyone in your family overweight? ❍ Mother ❍ Father ❍ Sibling ❍ Grandparent

10) Were you overweight as a child? YES NO If yes, at what age(s)? _____

Fitness History:

1) When were you in the best shape of your life? _____

2) Have you been exercising consistently for the past 3 months? YES NO

3) When did you first start thinking about getting in shape? _____

4) What if anything stopped you in the past? _____

5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)?_____

Nutrition Related Questions:

1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? _____

2) How many times a day do you usually eat (including snacks)? _____

3) Do you skip meals? YES NO 4) Do you eat breakfast? YES NO

5) Do you eat late at night? ❍ Often ❍ Sometimes ❍ Rarely ❍ Never

6) What activities do you engage in while eating? (TV, reading etc) _____

7) How many glasses of water do you consume daily? _____

8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when?_____

9) Do you know how many calories you eat per day? YES NO If yes, how many?_____

10) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N
If yes, please list the supplements:
_____
_____

11) At work or school, do you usually: ❍ Eat out ❍ Bring food

12) How many times per week do you eat out? _____

13) Do you do your own grocery shopping? YES NO

14) Do you do your own cooking? YES NO

15) Besides hunger, what other reason(s) do you eat?
❍ Boredom ❍ Social ❍ Stressed ❍ Tired ❍ Depressed ❍ Happy ❍ Nervous

16) Do you eat past the point of fullness? ❍ Often ❍ Sometimes ❍ Rarely ❍ Never

17) Do you eat foods high in fat and sugar? ❍ Often ❍ Sometimes ❍ Rarely ❍ Never

18) List 3 areas of your Nutrition you would like to improve:

a._____ b._____ c._____

Exercise Related Questions: Skip to next section if you are presently inactive.

1) How often do you take part in physical exercise?

5-7x/week 3-4x/week 1-2x/week

2) 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_____

3) For how long have you been consistently physically active? _____

4) What activities are you presently involved in?

Cardio &/or Sports Frequency/Week Average Length Easy/Mod/Hard

_____

_____

Is cardio conditioning an area that you would like us to help you with? YES NO

Strength Training Frequency/Week Average Length Easy/Mod/Hard

_____

List exercises: _____

_____

_____

Would you like some assistance with your muscle conditioning program? YES NO

Stretching Frequency/Week Average Length

_____

Would you appreciate some help with a stretching program? YES NO

5) Please circle all the activities that interest you:

Group Fitness Classes	Snowshoeing	Football
Private Personal Training	Cross Country Skiing	Soccer
Partner Training	Hiking	Swimming
Boxing workouts	Golf	Tennis
Indoor Cycling	Basketball	Triathlon
Pilates/Yoga	Baseball	Volleyball
Running Programs	Rockclimbing	Kayaking
Walking Programs	Skiing/Snowboarding	White Water Rafting

Developing your Fitness Program:

1. Please circle how/when you prefer to exercise:

a) LARGE GROUPS SMALL GROUPS ALONE COMBINATION

b) MORNING AFTERNOON EVENING

2. Realistically, how often a week would you like to exercise? _____x/week

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

4. Based on your schedule and our facility location, where will most workouts take place?

NWPT Club/Studio Home Another Gym Outside Work Gym

5. 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 1x/two weeks 1x/month Other:_____

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

M T W T F S S

7. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent, etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Goal Setting:

How can we best help you? Please check that which applies.

❍ Lose Body Fat ❍ Develop Muscle Tone ❍ Rehabilitate an Injury ❍ Nutrition Education ❍ Start an Exercise Program ❍ Design a more advanced program ❍ Safety
❍ Sports Specific Training ❍ Increase Muscle Size ❍ Fun ❍ Motivation

Other_____

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

S= Specific (Provide details, how long, how much etc.)
M= Measurable (How will you measure whether you've reached your goals)
A= Attainable (Be realistic, set smaller goals)
R = Rewards-Based (Attach a reward to each goal)
T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

a)_____

b)_____

c)_____

2. How important is it for you to achieve these goals? ❍ Very ❍ Semi ❍ Not very

3. How long have you been thinking about achieving these goals? _____

4. How will you feel once you've achieved these goals? Be specific.

_____
_____
_____
_____

5. Where do you rate health in your life? ❍ Low priority ❍ Medium Priority ❍ High priority

6. How committed are you to achieving your fitness goals? ❍ Very ❍ Semi ❍ Not very

7. What do you think is the most important thing your Personal Trainer can do to help you achieve your fitness goals?

_____
_____
_____
_____

8. Outline what you feel are the obstacles or your potential actions, behaviors, or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise, etc.).

_____
_____
_____

9. Outline 3 methods that you plan to use to overcome these obstacles:

a. _____ b. _____ c. _____

Miscellaneous Questions:

1. How did you hear about us? Please check applicable source.

❍ Brochure ❍ Yellow Pages ❍ Website ❍ Drop-in
❍ Word of Mouth Referral – Who?_____
❍ Newspaper/Magazine Column or Ad – Which one? _____
❍ Flier in local business – Where? _____
❍ Chamber of Commerce/Networking Event ❍ Other_____

2. Why did you choose to train with Yvette Salva Fitness instead of another organization? Please check that which applies.

❍ Location ❍ Personal Trainers ❍ Cost ❍ Customer Service ❍ Word of Mouth Referral
❍ Programs ❍ You heard we were the best ❍ You know we are going to produce results
❍ Other_____

3. How far do you live from our training studio? _____miles

4. Which newspaper(s) do you read? _____

5. Which radio station(s) do you listen to? _____

6. Which local magazine(s) do you read? _____

7. Which local morning TV show do you watch? _____

8. What would cause you to discontinue training with us?
_____