



PRE-TRAINING CLIENT QUESTIONNAIRE

Today's Date: _____ Birth Date: _____ Age: _____ Sex: _____
Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Occupation: _____
Last Physical Exam: _____ Referred By: _____
Emergency Contact: _____ Phone: _____

Upcountry Fitness wants to provide the highest quality or service possible. The following will be used to design your personal fitness program.

MEDICAL HISTORY

These conditions affect your ability to exercise. Please check the items that apply to you:

- Sensitive to touch/pressure in any area
- Frequent headaches
- Pregnant If yes, when are you due: _____
- High blood pressure
- Surgery
- Broken bones at any point in life
- Fatigue or lack of energy
- Advised by a physician to avoid any type of exercise
Explain: _____
- Have a cardiac condition
- Currently taking any medications
- Smoke or have in past

Have you ever had any of the following?

- Physical therapy
- Chiropractic
- Massage
- Active Release Technique
- Acupuncture
- Feldenkrais
- Rolfing
- Alexander technique
- Other: _____

Back or neck problems? If yes, please explain with date of occurrence:

Circle current level of back or neck pain: 1 2 3 4 5 6 7 8 9 10

Any other musculoskeletal problem?

- ankles pelvis elbows injury to nerves injury to tendons
- knees shoulder wrist injury to muscles injury to ligament

If yes, please explain with date of occurrence and current level of pain (1-10):

Any other medical condition you have or have had that we should know about (arthritis, thyroid, car accident, fall, clinical depression, elective surgical procedures, etc) Please explain:

LIFESTYLE

Do you often feel anxious, tense, under pressure or stressed? (Circle one)

Almost Never

Occasionally

Frequently

All the Time

How would you describe your eating habits?

EXERCISE GOALS AND INTENT

What is your main goal for exercising?

Postural re-education

Improve cardiac capacity

Sports-specific training

Body building

What sport? _____

Shaping and toning

Post-rehab

Fat loss

Recovering from injury

Lowering blood pressure or cholesterol

Overall health

Other: _____

What is your ultimate outcome? In six month's time how would you ideally like to describe your body, physical vitality or performance? _____

Why is the outcome important to you? _____

Are you participating in any physical activity now? What and how often? _____

If not, how long has it been since you've been involved in a regular exercise program?

What activities would you like to include into your daily routine? _____

How serious are you towards accomplishing your health and fitness goals?

Uncommitted

1 2 3 4 5 6 7 8 9 10

Fully Dedicated

Have you ever had a health/fitness program designed for you by a professional trainer before? If so, how long ago? Did you have a favorable outcome? _____

How much time per week are you willing to commit towards accomplishing your fitness goals?

What days work best for you in the gym?

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

a.m.
p.m.

a.m.
p.m.

a.m.
p.m.

a.m.
p.m.

a.m.
p.m.

a.m.
p.m.

a.m.
p.m.