Return to Form – New Client Forms

Name: _____

Date: _____ Address: _____

City:_____ Province: _____ Postal Code:_____

Email address: _____ (please print carefully)

Gender: _____Male _____Female Occupation: _____

Day Phone: _____ Evening: _____ Cell: _____

Preferred Method of Contact: _____

Emergency Contact: _____ Phone #: _____

Doctor: _____ Phone#: _____

PHYSICAL ACTIVITY HISTORY

Height: _____ Weight: _____ Age: _____ Date of Birth:_____

Sleep habits (how long, how well): _____

Please describe your training history (how many months or years, how consistent, what type of training, ie weight training, cardio, sports, etc):

_____

_____

_____

In the past three months, how often have you engaged in physical activity?

_____ 3 or more times a week _____2 times a week _____ Less than once a week

What's your current exercise regime (how often, how long, what type of training and training split, how much cardio, if any)?

_____

_____

_____

MEDICAL HISTORY

Circle any that apply to you:

Low back pain	Neck pain	Asthma
Diabetes	High blood pressure	Low blood pressure
Headaches		

Anything else you would like to mention: _____

_____

Any surgeries or injuries: _____

_____

TRAINING GOALS AND EXPECTATIONS

What is your primary training goal?

_____

_____

_____

Secondary training goal?

_____

_____

What are your personal barriers for not sticking to your previous program?

_____

_____

_____

NUTRITIONAL CONSIDERATIONS

What's your diet like?

_____

_____

_____

Do you take any supplements? If yes, which, how much and how often?

_____

_____

ADDITIONAL INFORMATION

Is there anything else your trainer might need to know about you or your training circumstances in order to create an effective program for you?

_____

_____

_____

_____

_____

_____

_____