Initial Assessment

PART I. Personal Information

Name ____________________ Date ____________

Address ____________________ Primary Phone # ____________

Email ____________________ Secondary Phone # ____________

Date of Birth ________ Age ______ Age you feel? ________ Date of Last Physical ____________

Emergency contact ________ Phone # ________ Occupation ________ How did you find us?

PART II. Medical History

Have you had any family history of chronic disease (heart disease, diabetes, etc.)? YES / NO
IF YES please list ____

Have you ever been diagnosed or treated for any chronic disease including asthma? YES / NO
If YES please list ____

Are you currently taking any medications? YES / NO
IF YES please list____

Have you ever had your thyroid hormone levels checked? YES / NO
IF YES please elaborate____

PART III. Health Related Behavior

Do you smoke? YES / NO IF YES how much?______________________________

Do you drink alcohol regularly? YES / NO IF YES how much?_____________________

How many times on average do you eat fast food per week?
Never 1 2 3 4 5 6 7 8 9 10 or more

How many hours of sleep do you normally get per night?
1 2 3 4 5 6 7 8 9 10 or more

PART IV. Psychological

I am an impatient, time conscious, hard driving individual.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

I have a positive attitude towards things.
Never 1 2 3 4 5 6 7 8 9 10 *Always*

My job stresses me out.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

I am in the best shape of my life.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

I would rate my current health.
Horrible 1 2 3 4 5 6 7 8 9 10 *Great*

I am serious about achieving my goals.
Not very 1 2 3 4 5 6 7 8 9 10 E*xtremely*

PART V. Goals

Do you have any health related goals (i.e. lower blood pressure, etc.)? YES / NO
IF YES please list____
____

Do you have any specific goals related to body composition (i.e. weight loss, build muscle, etc.)? YES / NO
IF YES please list____
____

Do you wish to achieve any of these goals in a specific time frame? YES/NO
IF YES please explain____

FITNESS STATUS

PART I. Fitness Information

What type of duties do you perform at work?
____
____
____

Have you had any injuries related to physical activity? YES / NO
If YES please list____

Do you suffer from any chronic pain? YES / NO
If YES please list____

Have you ever participated in resistance/weight training before? YES / NO
If YES, did you receive any instruction? YES / NO

Have you ever trained with a personal trainer before? YES / NO
IF YES, please explain: ____

Are you currently involved in an exercise regimen? YES / NO
IF YES, please list forms of exercise: ____
IF NO, when were you last exercising routinely? ____________________________________

How many days per week do you accumulate 30 minutes of moderate activity?
0 1 2 3 4 5 6 7 *days per week*

How many days per week do you accumulate at least 20 minutes of vigorous activity
(i.e. continuous heavy lifting or sprinting)?
0 1 2 3 4 5 6 7 *days per week*

PART II. Psychological

When would you say you were in the best shape of your life? How did you feel?
____

I would rate my current physical fitness.
Horrible 1 2 3 4 5 6 7 8 9 10 *Great*

My physical fitness is important to me.
Not very 1 2 3 4 5 6 7 8 9 10 *Extremely*

I enjoy exercising.
Not very 1 2 3 4 5 6 7 8 9 10 *Extremely*

I can succeed in achieving my goals.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

PART III. Goals

Do you have any performance or fitness related goals (i.e. increase 10K time, bench press)?
YES / NO
IF YES please list____
____

Do you wish to achieve these goals in a specific time frame? YES/NO
IF YES please explain: ____

PART IV. Training Preferences

I enjoy to be pushed (challenged) to the limit.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

I am willing and able to perform recommended exercise (i.e. cardio, stretching, etc.) on my own time.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

How many personal training sessions per week is desirable?
1 2 3 4 5 6 7 *Depends on trainer's recommendation*
Please list preferred days and times are you available for personal training sessions.

Do you have any friends who may be interested in personal training? YES/NO

Name: ________________ Email: ______________________________ Phone: __________________

Name: ________________ Email: ______________________________ Phone: __________________

Name: ________________ Email: ______________________________ Phone: __________________

PART V. Questions

Please write your top 2 fitness related questions?

____
____
____
____

NUTRITION STATUS

PART I. Personal Information

Have you worked with a nutritionist or used a diet program (i.e. Weight Watchers) before? YES / NO

If YES what were the results?____

Have you been on a diet before (i.e. Atkins, zone, etc.)? YES / NO
If YES what were the results____

How long did the diet/results last____

PART II. Nutrition Knowledge

Do you know how to differentiate between Carbohydrates, Fats, and Proteins? YES / NO

Do you understand what a Calorie represents? YES / NO
If YES please explain____

Do you understand the concept of caloric balance? YES / NO
If YES please explain____

PART III. Nutrition Habits

How long after you wake up before you consume your first meal on average?
Less than 1 hour 1 an hour or more 1-2 hours 3 or more hours

How many times do you eat per day on average?
1 2 3 4 5 6 7 8 9 10 or more

I eat in response to stress.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

PART IV. Fluid Choices

How many cups of water do you drink per day on average (1 cup = 1 glass)?
0 1 2 3 4 5 6 7 8 9 10 or more

How many servings of juice/drink (i.e. Snapple, orange juice) do you drink per day on average?
0 1 2 3 4 5 6 7 8 9 10 or more

How many servings of regular soda do you drink per day on average (1 serving = 1 12oz. can)?
0 1 2 3 4 5 6 7 8 9 10 or more

How many cups of caffeinated beverages (i.e. coffee, tea) do you drink per day?
0 1 2 3 4 5 6 7 8 9 10 or more

PART V. Food Choices

How many servings (1 cup or size of fist) of vegetables do you eat per day on average?
0 1 2 3 4 5 6 7 8 9 10 or more

How many servings (1 cup or size of fist) of protein (meat) do you eat per day on average?
0 1 2 3 4 5 6 7 8 9 10 or more

How many servings (1 cup or size of fist) of carbohydrates (i.e. Potatoes, bread, pasta, cereals) do you eat per day on average?
0 1 2 3 4 5 6 7 8 9 10 or more

How many times per week on average do you eat candy & dessert foods?
0 1 2 3 4 5 6 7 8 9 10 or more

PART VI. Psychological

I would rate my current diet.
Horrible 1 2 3 4 5 6 7 8 9 10 *Great*

I would rate my self-discipline with regards to eating.
Horrible 1 2 3 4 5 6 7 8 9 10 *Great*

I feel comfortable limiting my food intake by counting calories.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

I am serious about achieving my goals.
Not very 1 2 3 4 5 6 7 8 9 10 *Extremely*

PART VII. Dietary Supplements

Do you currently take any dietary supplements? YES / NO
If YES please list____

Have you taken dietary supplements in the past? YES / NO
If YES what were the results____

I'm willing to incorporate dietary supplements into my training program.
Disagree 1 2 3 4 5 6 7 8 9 10 *Agree*

PART VIII. Fitness/Physical Assessment (To be completed by the Trainer)

This section is for the Trainer to complete client's vital/stats as well as physical and fitness assessment.

NAME: ______________________________ ***DATE:*** __________

Overhead Squat Test

Anterior View		Right YES	Left YES	Lateral View (Right Side)		YES	Posterior View		Right Yes	Left YES
Foot	Foot Turns Out			**L-P-H-C**	Excessive Forward Lean		**Foot**	Heel of Foot Rises		
Knee	Moves Inward				Low Back Arches			Foot Flattens		
	Moves Outward				Low Back Rounds		**L-P-H-C**	Asymmetrical Weight Shift		
				Upper Body	Arms Fall Forward					

MODIFIED:	HEELS ELEVATED	ARMS DOWN
FEET		
KNEES		
LPHC		
UPPER		

NOTES:

Single Leg Squat Test

RIGHT Leg			LEFT Leg		
		Right YES			Left YES
Foot	Foot Flattens		**Foot**	Foot Flattens	
Knee	Moves Inward		**Knee**	Moves Inward	
	Moves Outward			Moves Outward	
L-P-H-C	Hip Hike		**L-P-H-C**	Hip Hike	
	Hip Drop			Hip Drop	
Upper Body	Inward Trunk Rotation		**Upper Body**	Inward Trunk Rotation	
	Outward Trunk Rotation			Outward Trunk Rotation	

NOTES:

Vital/Stats

______pounds ______inches __________mm/hg _________B.P.M.
Weight Height Blood Pressure Resting Heart Rate

Body Composition Assessment

______ ______ __________lbs/kg
BF% Fat Mass Weight

Measurements

______ ______ ______ ______ ______ ______ ______
Neck Chest Waist Hip Thigh R/L Calf R/L Biceps R/L