

### Client Profile

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Body Fat % \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

Emergency Contact / Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Trainer Preference:    Male    Female

The ideal time and days I'd like to workout are: \_\_\_\_\_

I am signing up for (please circle all that apply):

- Personal Training     Pilates     Parisi (Sports Performance)  
 Urban Workout     Corrective Exercise     Weight Loss     Young At Heart (senior fitness)

Trainer's Name: \_\_\_\_\_

### Physical Activity Readiness Questionnaire (PAR-Q)

Yes	No	Questions
		Has your doctor ever said you have a heart condition and that you should only do 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 any physical activity?
		Do you lose your balance because of dizziness or do you ever lose consciousness?
		Do you have a bone or joint problem that could be made worse by a change in your physical activity?
		Is your doctor currently prescribing drugs for your blood pressure or heart condition?
		Do you know ANY other reason why you should not do physical activity?

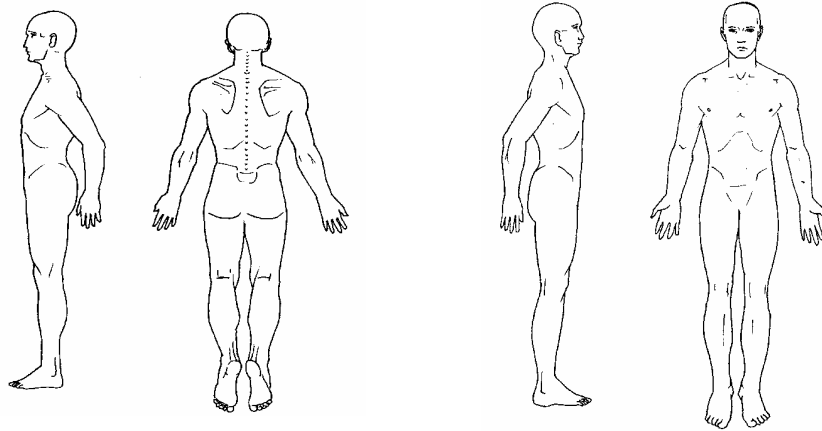
*If you have answer YES to one or more questions, consult your physician by telephone or in person BEFORE increasing your physical activity. Tell your physician what questions you answered YES to and/or present this copy. After medical evaluation, seek advice from your physician on what's suitable for your needs. If you have answered NO to all questions, please proceed.*

**I have read, understood, and completed this questionnaire. Any questions I had were answered to my full satisfaction.**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date \_\_\_\_\_

### Health Profile

1. Are there any health concerns (heart disease, pacemaker, pregnant, recent surgery, smoker, asthma, diabetes, high blood pressure, taking medications, etc.) that we need to know about?
  
2. Do you have **ANY** injuries, aches, or pains (recent or old)? Do you suffer from pain in the shoulders, low back, knees, or hips? Are there any movements that seem to worsen the pain? Please describe below.
  
3. Please indicate type of discomfort by placing the appropriate symbol on the diagram below.
  - a. Pain XXXXX
  - b. Tingling //
  - c. Numbness OOOO
  - d. Stiffness +++++



### FITNESS GOALS

1. What goals are the most important to you? What motivated you to start today?
  
2. What are the biggest obstacles that have prevented you from achieving your goals in the past?
  
3. In what way(s) do you think the trainer can help you the most?

## *EXERCISE HISTORY*

1. Are you currently participating in an exercise program now? Please describe your program (days per week, minutes per workout, weights, cardio, stretching, classes, etc.).
2. How would you evaluate your current level of health and fitness?
3. What types of sports and/or recreational activities (skiing, hiking, running, cycling, etc.) do you like to participate in now? If you are not participating now in one, is there something you are interested in doing?
4. How many days a week can you dedicate to your individualized program? \_\_\_\_\_
5. How much time can you dedicate **PER SESSION** to your program? \_\_\_\_\_

## *Life Style / Health Profile*

1. What is your occupation? Does your job require prolonged sitting or driving, any repetitive movements (computer, reading, and writing)? Please explain your occupation, along with the physical and mental responsibilities involved.
2. How would you rate your overall stress level (low, medium, or high)? Please explain.
3. How many hours of sleep do you get at night? Do you feel rested when you wake up?

## *DIET / NUTRTION*

1. How would you evaluate your current eating regimen?
2. Do you eat a balanced macronutrient (proteins, carbohydrates, fats) diet at each meal?
3. Do you go long periods between meals and then binge eat?
4. Do you feel you would benefit from more nutritional guidance?

## *CARDIOVASCULAR TRAINING*

1. How would you evaluate your current cardiovascular program?
2. Are you interested in having a cardio program designed for you and your specific goals?