Client Information Questionnaire:

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:______

Residential Address:____

Same as your mailing? YES NO: ____

Phone: ___________________

Email address: ____

Occupation:_______________________________________

Emergency Contact: ________________________ Relationship: _________________

Phone Number:_________________________

PAR-Q FORM Please circle YES or No to the following:

- Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? YES NO
- Do you frequently have pains in your chest when you perform physical activity? YES NO
- Have you had chest pain when you were not doing physical activity? YES NO
- Do you lose your balance due to dizziness or do you ever lose consciousness? YES NO
- 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.)? YES NO
- Are you pregnant now or have given birth within the last 6 months? YES NO
- Have you had a recent surgery? YES NO

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

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Please list any injuries/restrictions you may have:

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