

INDIVIDUAL PROFILE

Name

Date

Street Address

City

Zip

Home Phone

Work Phone

Cell Phone

E-mail

Referred By

Age

Date of Birth

Primary Care Provider & Contact #

Occupation

General and Medical Information

Please complete this general and medical history form prior to your first training session. All information will be kept confidential. This information, in conjunction with a physical assessment will be used to design a comprehensive program that meets your individual goals and needs. It is important to fill out the form carefully and thoroughly. Thank you.

1. Rank your goals in order of importance (1=most important; 10=least important):

___ Improved Strength

___ Post-Rehabilitation

___ Improved Cardio Fitness

___ Reduce Back Pain

___ Fat Loss

___ Improve Sports Performance

___ General Fitness

___ Reduce Stress

___ Build Muscle

___ Improve Flexibility

___ Improved Function

___ Injury Prevention

___ Bodybuilding

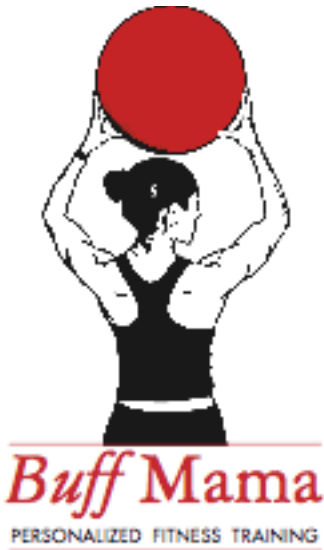
___ Increase Energy

___ Tone-Up

___ Stay Youthful

___ Rehabilitation

___ Have Fun With Exercise



2. Specify sport(s) and/or other training objectives not listed:

3. Are you currently involved in a regular exercise program? Yes No

If yes, please list how long you have participated in this program and what type of exercises you perform: _____

4. Have you experienced a professional personal training session previously? Yes No

5. How many days/hours per week will you dedicate to your individualized program? Min./day _____

Circle Days: Mon Tues Wed Thurs Fri Sat Sun

6. Do you feel stressed out everyday or are your days very manageable and without stress? What are the sources: _____

7. Describe a typical day. Include average time sitting, standing, walking and lifting/carrying load: _____

8. Do you consider yourself:

Sedentary Moderately Active Active Highly Active

9. What types of hobbies or sports do you enjoy playing or participating in?

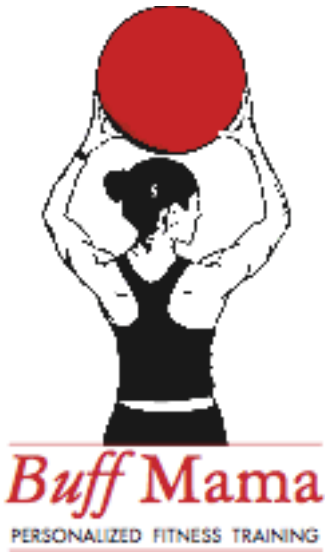
10. How do you learn things best?

- (a) watching and seeing
- (b) hearing and listening
- (c) feeling and touching

11. How many hours do you sleep regularly at night? _____

12. Do you consider yourself:

- (a) bounce off the wall type of person
- (b) a happy go lucky type of guy/gal
- (c) a low energy, get me to my bed!



13. How much “perk me up” do you consume per day (coffee, soda, tea)?

14. How much natural “perk me up” do you consume per day (water)?

15. What do you eat on a normal day?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

16. Would you like some assistance in nutrition? Yes No

17. When do you prefer to exercise?

Morning

Afternoon

Evening

18. Were you a high school or college athlete? _____

If yes, please specify _____