
# 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
____ Improved Cardio Fitness
____ Fat Loss
____ General Fitness
____ Build Muscle
____ Improved Function
____ Bodybuilding
____ Tone-Up
____ Rehabilitation
____ Post-Rehabilitation
____ Reduce Back Pain
____ Improve Sports Performance
____ Reduce Stress
____ Improve Flexibility
____ Injury Prevention
____ Increase Energy
____ Stay Youthful
____ 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 _____