



# Personal Training by Nathan



## New Client Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Occupational Information	Yes	No
1. Current Occupation: _____		
2. Does your occupation require extended periods of sitting?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your occupation require extended periods of repetitive motion? (If yes, please explain). _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your occupation require you to wear shoes with a heel (dress shoes)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your occupation cause you anxiety?	<input type="checkbox"/>	<input type="checkbox"/>

Exercise Information	Yes	No
1. Are you actively exercising now? If so, please describe. _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.) _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
3. What are your fitness goals? _____ _____		
4. How much time per week, and/or how often would you like workout? _____		

Medical Information	Yes	No
1. Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you feel pain in your chest when you perform physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past month, have you had chest pain when you were not performing any physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a bone or joint problem that could be made worse by a change in your physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you lose balance because of dizziness or do you ever lose consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you know of any other reason why you should not engage in physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever had any pain or injuries (ankle, knee, hip, back, shoulders, etc.)? (If yes, please explain). _____	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had any surgeries? (If yes, please explain.) _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol, or diabetes? (If yes, please explain.) _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you currently taking any medication? (If yes, please list.) _____	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:**

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Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Trainers Signature \_\_\_\_\_ Date \_\_\_\_\_