

### CLIENT INFORMATION PACKAGE

Please complete and return to your Personal Trainer at least 2 days prior to your first scheduled session.

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 interests and is safe and effective.

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

Date of Birth     /     /      
                  M      D      Y

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (F) \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

Please provide 24 hours notice if you need to cancel or reschedule your Personal Training appointment.

Personal Trainer: \_\_\_\_\_

1st Appointment: \_\_\_\_\_



780.482.7030

INFO@DEFININGEVE.COM

WWW.DEFININGEVE.COM

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

**YES NO**

1) Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? \_\_\_\_\_

2) Do you frequently have pains in your chest when you perform physical activity? \_\_\_\_\_

3) Have you had chest pain when you were not doing physical activity? \_\_\_\_\_

4) Do you lose your balance due to dizziness or do you ever lose consciousness? \_\_\_\_\_

5) 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.)? \_\_\_\_\_

6) Are you pregnant now or have given birth within the last 6 months? \_\_\_\_\_

7) Have you had a recent surgery? \_\_\_\_\_

8) If you have marked YES to any of the above, please elaborate below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9) Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No

10) What is the medication for? \_\_\_\_\_

11) How does this medication affect your ability to exercise or achieve your fitness goals? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Lifestyle Related Questions:**

1) Do you smoke? YES NO

2) Do you drink alcohol? YES NO if yes, how many glasses per week? \_\_\_\_\_

3) How many hours do you regularly sleep at night? \_\_\_\_\_

4) Describe your job:  Sedentary  Active  Physically Demanding

5) Does your job require travel? YES NO

6) On a scale of 1-10, rate your stress level (1=very low-10=very high)? \_\_\_\_\_

7) List your 3 biggest sources of stress:

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

8) Is anyone in your family overweight? (circle) Mother / Father / Sibling / Grandparent

9) Were you overweight as a child? YES / NO if yes, at what age(s)? \_\_\_\_\_

**Fitness History:**

- 1) When were you in the best shape of your life? \_\_\_\_\_
- 2) Have you been exercising consistently for the past 3 months? YES NO
- 3) When did you first start thinking about getting in shape? \_\_\_\_\_
- 4) What if anything stopped you in the past? \_\_\_\_\_
- 5) On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)? \_\_\_\_\_

**Nutrition Related Questions**

- 1) On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)? \_\_\_\_\_
- 2) How many times a day do you usually eat (including snacks)? \_\_\_\_\_
- 3) Do you skip meals? YES NO
- 4) Do you eat breakfast? YES NO
- 5) Do you eat late at night?  Sometimes  Often  Never
- 6) What activities do you engage in while eating? (TV, reading etc) \_\_\_\_\_
- 7) How many glasses of water do you consume daily? \_\_\_\_\_
- 8) Do you feel drops in your energy levels throughout the day? YES NO If yes, when? \_\_\_\_\_
- 9) Do you know how many calories you eat per day? YES NO If yes, how many? \_\_\_\_\_
- 10) Are you currently or have you ever taken a multivitamin or any other food supplements? Y N  
If yes, please list the supplements: \_\_\_\_\_  
\_\_\_\_\_
- 11) At work or school, do you usually:  Eat out  Bring food
- 12) How many times per week do you eat out? \_\_\_\_\_
- 13) Do you do your own grocery shopping? YES NO
- 14) Do you do your own cooking? YES NO
- 15) Besides hunger, what other reason(s) do you eat?  
 Boredom  Social  Stressed  Tired  Depressed  Happy  Nervous
- 16) Do you eat past the point of fullness?  Often  Sometimes  Never
- 17) Do you eat foods high in fat and sugar?  Often  Sometimes  Never
- 18) List 3 areas of your Nutrition you would like to improve:  
a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

**Exercise Related Questions:** Skip to next section if you are presently inactive.

1) How often do you take part in physical exercise?

5-7x/week      3-4x/week      1-2x/week

2) If your participation is lower than you would like it to be, what are the reasons?

Lack of Interest      Illness/Injury      Lack of Time      Other \_\_\_\_\_

3) How long have you been consistently physically active for? \_\_\_\_\_

4) What activities are you presently involved in?

Cardio &/or Sports	Frequency/Week	Average Length	Easy/Mod/Hard
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Strength Training	Frequency/Week	Average Length	Easy/Mod/Hard
_____	_____	_____	_____

List exercises: \_\_\_\_\_  
\_\_\_\_\_

Stretching	Frequency/Week	Average Length
_____	_____	_____

5) Please circle all the activities that interest you:

Aerobic Fitness Classes	Indoor Cycling	Snowshoeing
Baseball	Kayaking	Soccer
Basketball	Partner Training	Swimming
Boxing	Pilates	Tennis
Cross Country Skiing	Private Personal Training	Triathlon
Football	Racquetball	Volleyball
Golf	Rockclimbing	Walking
Group Personal Training	Running	Wallyball
Hiking	Skiing	White Water Rafting
Ice Skating	Snowboarding	Yoga

**Developing your Fitness Program:**

1. Please circle how you prefer to exercise:

- a)      INSIDE                      OUTSIDE                      COMBINATION
- b)      LARGE GROUPS      SMALL GROUPS      ALONE                      COMBINATION
- c)      MORNING      AFTERNOON      EVENING

2. Realistically, how often a week would you like to exercise? \_\_\_\_\_x/week

3. Realistically, how much time do you have during each exercise session? \_\_\_\_\_

4. What are the best days during the week for you to commit to your exercise program?

M      T      W      T      F      S      S

5. If you could design your own exercise program, what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

**Goal Setting:**

**How can a Personal Trainer help you? Please check that which applies.**

- Lose Body Fat   
  Develop Muscle Tone   
  Rehabilitate an Injury   
  Nutrition Education   
  Start an Exercise Program   
  Design a more advanced program   
  Safety   
  Sports Specific Training   
  Increase Muscle Size   
  Fun   
  Motivation  
 Other \_\_\_\_\_

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

- S= Specific (Provide details, how long, how much etc.)
- M= Measurable (How will you measure whether you've reached your goals)
- A= Attainable (Be realistic, set smaller goals)
- R = Rewards-Based (Attach a reward to each goal)
- T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_

2. How will you feel once you've achieved these goals? Be specific.

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3. Where do you rate health in your life?     Low priority     Medium Priority     High priority

4. How committed are you to achieving your fitness goals?  Very  Semi  Not very

5. What do you think the most important thing your Personal Trainer can do to help you achieve your fitness goals?

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6. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over exercise etc.).

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7. Outline 3 methods that you plan to use to overcome these obstacles:

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

**Miscellaneous Questions:**

1. How did you hear about us? Please check all that apply.

- Brochure  Word of Mouth  Yellow Pages
- Website  Store (if so which store?) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

2. If you were referred to us, who told you about our services?

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3. Which newspaper(s) do you read? \_\_\_\_\_

4. Which radio station(s) do you listen to? \_\_\_\_\_

5. Which local magazine(s) do you read? \_\_\_\_\_

6. Which local morning TV show do you watch? \_\_\_\_\_

7. The Gift of Fitness:

At Defining Eve Personal Training we rely on happy clients telling others about our services. We may both be able to make a huge difference in somebody's life. Please take the time to jot down the names of 2 friends who you would like to offer a complimentary consultation to. Once you discuss this with them, we'll call them and book them for their first session.

Name	Phone
i. _____	_____
ii. _____	_____