CLIENT INTAKE FORM - PERSONAL TRAINING

PERSONAL INFORMATION

Full name: **Date of birth:**

Phone: **Email:**

Occupation: **Preferred schedule:**

GOALS AND MOTIVATION

Main goal:

Target timeframe: **Commitment level (1-10):**

Previous experience:

MEDICAL HISTORY AND INJURIES

Current or past injuries:

Current medications:

Relevant medical conditions:

Movement limitations:

PRE-EXERCISE HEALTH QUESTIONNAIRE

Has a doctor ever said you have a heart condition?	Yes [ ] No [ ]
Do you feel chest pain when you exercise?	Yes [ ] No [ ]
Have you lost balance or consciousness from dizziness?	Yes [ ] No [ ]
Do you have a bone or joint problem exercise could worsen?	Yes [ ] No [ ]
Do you take medication for blood pressure or your heart?	Yes [ ] No [ ]
Do you know of any other reason you should not exercise?	Yes [ ] No [ ]

STARTING MEASUREMENTS

Weight (kg): **Height (cm):** **BMI:**

Waist (cm): **Hips (cm):** **Body fat %:**

Date: **Client signature:**