

## NEW CLIENT QUESTIONNAIRE

Name \_\_\_\_\_

DATE \_\_\_\_\_

E-mail address \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Daytime or Work phone \_\_\_\_\_

Evening or Home phone \_\_\_\_\_

HEIGHT:  
WEIGHT:

Weight one year ago:

Why are you seeking a personal fitness trainer? Please check all reasons that apply:

- Muscle gain
- Bored with workouts
- Want to learn more about fitness and/or nutrition
- Recommended by physician, physical therapist, or other healthcare professional
- Sports-specific training
- Other training reasons \_\_\_\_\_

What is the ideal time to meet Cari for your strength training sessions?

- Early morning
- Mid-morning
- Lunch
- Evening *(these appointments are rare, I start my days at 5am and am not crazy about 14-hour workdays!)*
- Saturday mornings *(these time slots are rare too, maybe once per month!)*

Where is the ideal place to meet Cari for workouts?

- Home or gym at your work
- Spring Lake Fitness & Aquatic Center *(member or daily pass fee)*
- Spring Lake Country Club *(if you're already a member!)*
- Snap Fitness in Spring Lake
- Snap Fitness in Grand Haven
- Snap Fitness in Norton Shores
- Outdoors *(yes, year 'round - also check out www.ecotrekfitness.com)*

What weight would make you happy?

In what time frame?

Circle which area you live in:

Spring Lake   Grand Haven   Ferrysburg   Norton Shores   Muskegon  
Fruitport   Cloverville   Nunica   Crockery   Conklin/Ravenna   North Muskegon  
Coopersville   Marne   Holland   Zeeland   Allendale   Lamont   Walker

*If you don't see your area above, chances are pretty good that it's too far for Cari at the standard hourly rate; inquire how much it would be!*

## 2

Please give a brief description of the health and fitness goals you are trying to achieve or improve \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ENERGY

How are your energy levels throughout the day?  High  Moderate  Low

Do you lack energy or stamina during your workouts?

Yes  No

Do you get sleepy or lethargic after eating?

Yes  No

### NUTRITION

How many meals do you eat per day?  one  two  three  four  five  
 six or more

Do you skip meals?  Yes  No

If you skip meals, check which ones you skip on most days?

Breakfast  Lunch  Dinner

What time do you usually eat breakfast? \_\_\_\_\_

What time do you eat lunch? \_\_\_\_\_

What time do you eat dinner? \_\_\_\_\_

Do you eat snacks?  Yes  No When? \_\_\_\_\_

Do you crave sweets?  Yes  No

Do you crave carbohydrates?  Yes  No

How many servings of fruits and vegetables do you eat daily?

A serving equals 1/2 cup of cooked or raw vegetables; 1 cup of leafy vegetables; 1/2 cup of fresh, frozen or cooked fruit or 1/4 cup of dried fruit

none  one  two  three  four  five or more

How many cups of coffee, tea, soda, or other caffeinated beverages do you consume each day?

none  one  two  three  four  five or more

Are you sensitive to caffeine?

Yes  No

Are you lactose intolerant or allergic to any dairy products?

Yes  No

Are you allergic to any foods?

Yes  No If yes, what: \_\_\_\_\_

Are you currently dieting?

Yes  No If yes, what: \_\_\_\_\_

Are you currently taking a product to enhance weight loss?

Yes  No If yes, what: \_\_\_\_\_

**SUPPLEMENTATION**

Do you currently take any nutritional supplements?  Multi-vitamin  Vitamin C  
 Antioxidants  Essential Fatty Acids  Calcium  Iron  Other

Other: \_\_\_\_\_

Are you currently taking a protein supplement (shakes or bars) to round out your diet?

Yes  No

**DIGESTION**

How is your digestion?  Normal  Problematic

**FITNESS**

Are you currently participating in an exercise program?

Yes  No

Do you currently have access to a gym facility or have an active membership with a health club?

Yes  No

How many times a week are you doing some type of cardiovascular fitness (walking, jogging, running, exercising)?  none  once  twice  three times  four times  
 five times or more

Check below the types of cardiovascular fitness you currently participate in:

Walking  Jogging  Running  Treadmill  Elliptical training  Stationary bike  
 Recumbent bike  Bicycle  Aerobics class  Other \_\_\_\_\_

Are you currently weight training as a part of your exercise program?

Yes  No

If you are weight training, indicate what type of equipment you are using.

None  Free Weights  Machines  Other \_\_\_\_\_

What muscles fatigue quickly while weight training? Check all that apply.

Chest  Neck  Upper back  Mid back  Low back  Shoulders  
 Biceps  Triceps

What time of day do you exercise?  morning  afternoon  evening

Where do you currently exercise?  gym  home  work  other \_\_\_\_\_

Please list all sports you are currently participating in:

\_\_\_\_\_  
 Do you currently suffer from any joint pain from a previous injury (tendon, ligament, cartilage, etc.) that prevents you from being as active as you would like?

Yes  No

Do you have problems with muscle cramping during exercise or workouts?

Yes  No

Is there any reason at all (health or personal) that would limit/prevent you from exercising?

Yes  No

If you have exercise limitations, please list them below.

\_\_\_\_\_

**REST**

How many hours of sleep do you get on an average night?

less than four    five to six    seven    eight    nine or more

What time do you generally go to bed? \_\_\_\_\_

What time do you generally wake up? \_\_\_\_\_

Do you suffer from insomnia or have trouble sleeping?

Yes    No

**GENERAL HEALTH**

Do you consider yourself to have a high stress level?

Yes    No

Is your total cholesterol greater than 200?    Yes    No    not sure

Do you suffer from weak bones and/or joints?

Yes    No

Do you smoke?    Yes    No

If you smoke, how many packs per day?    less than one    one    two    three or more

Do you drink alcohol?    Yes    No

If you drink alcohol, how many drinks per week?    1-3    4-6    6-10    10 or more

**WOMEN'S HEALTH**

Are you post-menopausal?    Yes    No

Do you suffer from hot flashes?    Yes    No

Are you pregnant or lactating?    Yes    No

**MEDICAL INFORMATION**

Do you have any of the following conditions? Check all that apply

Asthma    Diabetes    Hyper thyroid    Hypo thyroid

High blood pressure    Heart problems    Coronary artery disease

Do you suffer from joint pain or any degenerative disease including osteoarthritis, osteoporosis, etc.?    Yes    No

Do you suffer from fibromyalgia or overall aches and pains?

Yes    No

Do you suffer from anxiety?

Yes    No

Do you ever feel faint or dizzy?

Yes    No

Are you currently taking any prescribed medications?    Yes    No

Have you had surgery in the past year?    Yes    No

*Thank you for filling out this questionnaire. Your information is NOT shared with or sold to other individuals or companies. All information included in this questionnaire is held strictly confidential.*