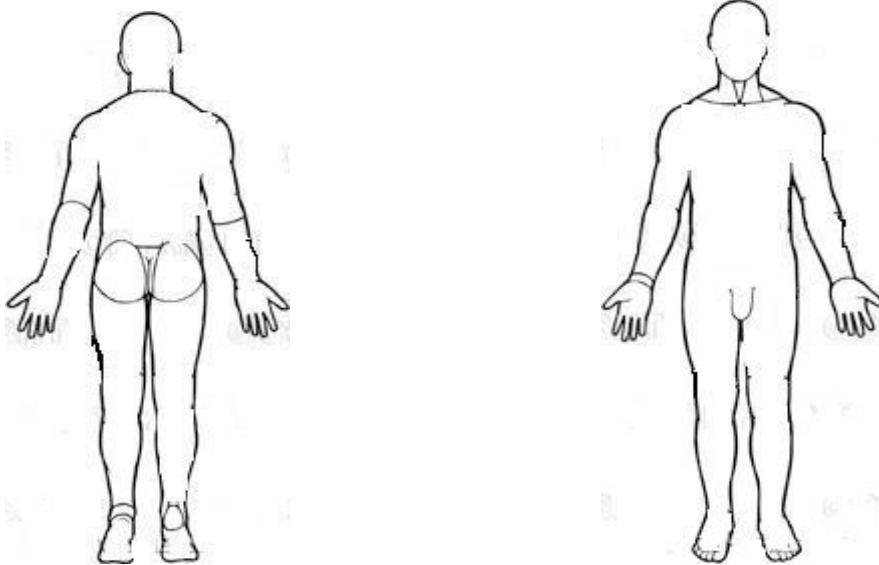


**Fitness Matters, Inc.**  
**Personal Training Consultation Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.  
Ideal Weight: \_\_\_\_\_ lbs. Contact phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

If visit is related to an injury, please specify: \_\_\_\_\_  
Onset Date: \_\_\_\_\_

**Please shade the areas that you have had symptoms:**



**Please describe these symptoms** \_\_\_\_\_

Have you been treated for this condition before? Yes (If yes, by whom? \_\_\_\_\_) No

**Please list any other previous orthopedic injuries or current areas of pain:**

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**How would you rank your level of stress?** High Moderate Low

How do you manage stress? \_\_\_\_\_

**Are you currently following a special diet?** Yes (type: \_\_\_\_\_) No

**Please list any medications you are currently taking:**

<u>Medication</u>	<u>Dosage / # times per day</u>	<u>Condition</u>	<u>Date started</u>
_____	_____/_____	_____	_____
_____	_____/_____	_____	_____
_____	_____/_____	_____	_____

**Past Medical History**

Please check if you have had any of the following conditions:

Chest pain with activity	_____	Do you smoke	_____
Chest pain at rest	_____	Depression/Anxiety	_____
Asthma/Bronchitis	_____	Headaches	_____
Shortness of Breath	_____	Vision difficulty	_____
Coronary Heart Disease	_____	Numbness/Tingling	_____
Pacemaker	_____	Dizziness/Fainting	_____
High Blood Pressure	_____	Weakness	_____
Heart Attack/Heart Surgery	_____	Weight/Energy Loss	_____
Blood Clot/Emboli	_____	Hernia	_____
Stroke/TIA	_____	Epilepsy/Seizures	_____
Allergies	_____	Thyroid issues	_____
Pins/Metal Implants	_____	Incontinence	_____
Joint Replacement	_____	Bowel/Bladder issues	_____
Diabetes	_____	Neck Injury	_____
Rheumatic Heart Disease	_____	Shoulder Injury	_____
Cancer/Chemotherapy	_____	Elbow/Hand Injury	_____
Arthritis	_____	Back Injury	_____
Osteoporosis	_____	Knee Injury	_____
Sleeping problems	_____	Leg/Ankle/Foot Injury	_____
Parkinson's	_____		

**FOR WOMEN ONLY:**

Pelvic Inflammatory Disease	_____	Endometriosis	_____
Irregular Menstrual Cycle	_____	Pelvic Pain	_____
Complicated Pregnancies	_____	Are you pregnant?	_____
Any Other Health Issues?	_____		

**Family History:**

Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset (if known) have ever been told they have:

Heart disease	_____	Hypertension	_____
Stroke	_____	Diabetes	_____
Cancer	_____	Other	_____

Are you currently involved in a regular exercise program? Yes No

If yes, please list the activity and the frequency:

Activity	Frequency	Equipment Used:
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you rank your level of enjoyment of exercise?

High            Moderate            Low

Please list your personal health goals:

\_\_\_\_\_  
\_\_\_\_\_

Strength and Toning goals:

- 1.) Upper Body \_\_\_\_\_
- 2.) Midsection \_\_\_\_\_
- 3.) Lower Body \_\_\_\_\_

Aerobic Training goals: \_\_\_\_\_

Recreational or Sport-Specific Goals:

Are you involved in any recreational activities or sports? \_\_\_\_\_

What areas would you like to improve for that activity? \_\_\_\_\_

\_\_\_\_\_

Weight Loss goals? Y N If yes, how much? \_\_\_\_\_

Number of days available to work out? \_\_\_\_\_

Time range of day you prefer to train? \_\_\_\_\_

Date desiring to start program? \_\_\_\_\_

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

Date: \_\_\_\_\_