WILDWOOD FAMILY CLINIC, S.C.
"HEALTHCARE FOR ALL AGES"

PERSONAL TRAINING

Name: _____ Date: _____

Address: _____

City: _____ State:_____ Zip:_____

Birthday:____/____/____ Sex: ☐ Male ☐ Female

Name of Gym: _____ Occupation:_____

Phone (home):_____ Phone (work):_____

Body Weight: _____ Body Fat:_____ Height: _____

Personal Goals

1. Primary Training and Nutrition Objectives (check one or more)

☐ Fat Loss	☐ Strength	☐ Weight Loss
☐ Build Muscle	☐ Shape and Tone	☐ Injury Rehabilitation
☐ Sport-specific Training	☐ Reduce Stress	☐ Increase Cardiovascular Endurance

2. What areas of your body do you specifically want to work on?

   _____

   _____

3. Training Experience:

☐ Sedentary	☐ Beginner	☐ Intermediate
☐ Upper-Intermediate	☐ Advance	☐ Pre-Contest or Preseason

4. Do you presently engage in physical activity? ☐ Yes ☐ No

   What kind? _____

   How Often? _____

5. Are you currently participating in a structured resistance training program?

   ☐ Yes ☐ No

   For how long? _____

6. Are you currently participating in a structured cardio respiratory program?

   ☐ Yes ☐ No

   For how long? _____

7. How often will you workout per week (circle one)

   3 (minimum) 5 6 7 8 9 10 other_____

8. What kind of cardiovascular activity do you enjoy most?

   ☐ Elliptical ☐ Stationary Bike ☐ Stationery Rower

   ☐ Stair Climber ☐ Treadmill ☐ Aerobics Class

   ☐ Other _____

Occupation

1. What is your current occupation? _____
2. Does your occupation require extended periods of sitting? ☐ Yes ☐ No
3. Does your occupation require extended periods of repetitive movements?

   ☐ Yes ☐ No

4. How many hours do you work or go to school? _____
5. On a scale from 1 to 10, what is your stress level? _____ Personal? _____

Habits

1. How many hours of sleep do you get per day? (average) _____
2. Have you ever suffered from insomnia? ☐ Yes ☐ No
3. How many meals do you eat daily? _____How many calories? _____
4. Do you eat meat? ☐ Yes ☐ No Favorite food: _____
5. Do you snack? ☐ Yes ☐ No Favorite snack: _____
6. Do you have any diet restrictions or allergies? ☐ Yes ☐ No

   If Yes:

   What? _____

   What Type? _____

7. Are you currently taking multivitamin, mineral or other type of food supplement? ☐ Yes ☐ No

   If yes:

   What are you taking? _____

   Why? _____
8. Do you smoke? ☐ Yes ☐ No If yes, how much? _____
9. Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____
10. Do you drink caffeine? ☐ Yes ☐ NO If yes, how much? _____
11. Are there any habits you would like to change?

    _____
12. Would you like to know what supplements would be integral to your success?

    ☐ Yes ☐ No

Medical History

Please check any of the following health problems you have or have been diagnosed with or treated by a health professional:

☐ Orthopedic Problems	☐ Heart Murmur	☐ Varicose Veins
☐ Injuries to back, Knees, ankles	☐ High Blood Pressure	☐ Lung Disease
☐ Brain concussion Head Injury	☐ Heart Attack/ Stroke	☐ Rheumatic
☐ Loss of Consciousness	☐ Heart Rhythm Abnormality	☐ Dizziness
☐ Epilepsy/Seizures	☐ Any type of Heart Problem	☐ Problems w/ Balance Vertigo
☐ High Stress	☐ Disease of Arteries	☐ Hypoglycemia
☐ Chest Pain Of any kind	☐ High Cholesterol	☐ Anemia
☐ Asthma		

☐ Arthritis, what kind? _____

☐ Diabetes, how long ago? _____

☐ Allergies, (hay fever etc.) _____

☐ Operations, what kind? _____

1. Old or recent injuries? _____
2. When was you last complete physical exam? _____
3. Are you currently taking medications? ☐ Yes ☐ No

   If Yes, What? _____
4. Is there any good reason not mentioned here why you should not follow an activity program even if you wanted to? _____

Family History

Have any of your blood relatives (brother, sister, parents, grandparents, aunts, uncles etc.) had:

☐ Heart Attack	☐ High Blood Pressure	☐ Congenital Heart Disease
☐ Heart Operation	☐ High Cholesterol	☐ Epilepsy
☐ Diabetes	☐ Other _____	

Wildwood Family Clinic

Waiver

I,_____ have read and understand, and answered the above health/medical survey questions fully and truthfully. I am aware of my responsibility to consult with my personal physician regarding my medical fitness to engage in strenuous exercise and a nutritional support program. I do hereby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the participating training facility, and the fitness trainer administering this instrument for any and all injuries suffered while following the training and/or nutrition program provide to me.

Client Signature _____ Date: _____

Print Clients Name: _____

Parent/Legal Guardian Signature _____