

KEEP N FIT

PERSONAL TRAINING



CLIENT PROFILE QUESTIONNAIRE

Date: _____ Home Phone: _____
Name: _____ Work Phone: _____
Address: _____ Cell Phone: _____
City: _____ Postal Code: _____
Email: _____
In Case of Emergency, Call: _____

GENERAL HEALTH & NUTRITION QUESTIONS

Personal Profile Information

Gender: Male / Female Height _____ / _____ Date of Birth: _____
Weight: _____ Body fat % _____

Lifestyle

How would you rate the activity level of your profession, or what you do during the day (non-exercise related)

___ Sedentary ___ Moderately Active ___ Active ___ Very Active

What time do you normally wake up? _____ What time do you normally go to bed at night? _____

If you smoke, how many per day? _____ If you smoke, how many years have you smoked? _____

Health & Medical Conditions

Check any that apply or describe any other(s).

___ Heart disease ___ Anemia ___ Hypoglycemia ___ Liver disease
___ Kidney disease ___ Diabetes ___ Pregnant/breastfeeding ___ High blood pressure
___ Other _____

Body Type

Which of the following statements best describes you?

___ I can eat practically anything I want and I do not gain weight. I find it very hard to gain weight.
___ I can lose or gain weight by adjusting my activity level and eating habits.
___ I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

Weekly Exercise Information

Explain in detail what type of resistance exercises, cardiovascular or sports activities you perform on average during a 7 day period.

Exercise/Activity	Days/week	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Goals

Weight Loss Increase Muscle/Strength Maintain/Improve Eating Habits Gain weight

If yes, what is your goal weight? _____

Protein Requirements

Which best describes you?

Sedentary adult Exercising adult Competitive athlete
 Growing teenage athlete Adult building muscle Athlete restricting calories

Dietary Preferences

Please list below everything you eat in one 24 hour period. Be sure to include snacks and beverages, including water. Also, show approximate amounts.

- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____
- Time : _____ Food/Beverage: _____

If you drink alcoholic beverages, what and how many per day? _____

Are you allergic to any types of foods? _____

Make a list of your favourite foods.

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Make a list of foods you dislike.

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Is there any additional information you feel would be beneficial for me to be aware of?
