ADELAIDE Personal Trainers

Pre-Exercise Questionnaire

Today's date:		Personal Trainer:	

PERSONAL DETAILS

Given names:		Surname:	
Preferred name:		DOB: / Age: / Sex: ☐ M ☐ F	
Street address: / Post code:		Email address:	
Postal address: / Post code:		Mobile no.:	
		Alternate no.:	☐ H ☐ W
Emergency contact		Mobile no.:	
Relationship		Alternate no.:	☐ H ☐ W

Discovered Adelaide Personal Trainers through:

☐ Family ☐ Friend ☐ Close to home or work ☐ Internet search ☐ Other (detail):

Names of family members or friends already training with us (if applicable):

OCCUPATION

Current occupation:		What physical tasks/common movements are involved in your job?	
How many hours per week do you work?			

HEALTH AND FITNESS GOALS AND EXERCISE HISTORY

What are your reasons for considering personal training?

Select the goals thar are important to you:

☐ Health	☐ Building lean muscle	☐ Strength
☐ Physical fitness	☐ Muscle toning	☐ Flexibility
☐ Weight maintenance	☐ Increase energy	☐ Improve self-esteem
☐ Weight loss	☐ Reduce stress	☐ Dedicate time for self
◯ 0 - 5 kg ◯ 10 - 20 kg	☐ Sport event training (detail/date):	☐ Upcoming social event (detail/date):
◯ 5 - 10 kg ◯ 20+ kg		

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HEALTH AND FITNESS GOALS AND EXERCISE HISTORY

How often have you exercised in the last 6 months?

☐ Never ☐ 4-5 times per week
☐ 1-3 times per week ☐ 5+ times per week

Duration of exercise:

☐ Up to 30 mins ☐ 30-60 mins
☐ 60-90 mins ☐ 90+ mins

Level of daily activity:

☐ Low ☐ Med ☐ High

Active hobbies (detail):

What exercise(s) do you enjoy? *(List any others)*

☐ Indoor ☐ Outdoor ☐ Group sport ☐ Floor/mat work ☐ Interval training ☐ Weight lifting ☐ Aeorobic/circuit work
☐ Hiking ☐ Boxing ☐ Gym equipment ☐ Other

Any particular likes/dislikes?

Have you ever had a regular exercise routine or played in group sport?

What exercise equipment do you have at home? *(If any)*

LIFESTYLE INFORMATION

Achieving your goals is not just about the exercise you do but about incorporating this with many other aspects of your life. The following helps to determine the impact these areas will have on your success.

Do you experience fatigue or lack of energy? *(Please detail)*

Rate the amount of stress in your career: *(1= least, 10= greatest)*

Rate the amount of stress in your personal life: *(1= least, 10= greatest)*

What time do you usually go to bed/wake in the morning?

Describe the quality of your sleep

How many cups/glasses of the following do you drink each week?

Coffee?

☐ Never ☐ 5-10 per week
☐ 1-5 per week ☐ 10+ per week

Alcohol?

☐ Never ☐ 5-10 per week
☐ 1-5 per week ☐ 10+ per week

Soft drink?

☐ Never ☐ 5-10 per week
☐ 1-5 per week ☐ 10+ per week

How many meals do you eat per day?

Describe your two largest meals.

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LIFESTYLE INFORMATION

How would you describe your diet?

How many times per week do you eat out or order take-away?

Have you previously dieted? *(Describe what diets you have tried).*

Have you seen a nutritionist, dietitian or naturopath? *(Please detail).*

Are you taking any supplements? *(Please detail).*

GENERAL HEALTH

Do you have any current medical conditions?

- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Stomach ulcer
- ☐ Chronic cough/pneumonia
- ☐ Hernia
- ☐ Cramps
- ☐ Epilepsy
- ☐ Asthma
- ☐ Backpain/injury/osteoporosis
- ☐ Arthritis/joint or muscular pain/ gout
- ☐ Breathing difficulty/shortness of breath
- ☐ Dizzy spells/light headedness/ seeing spots

When exercising do you experience chest discomfort, dizziness, breathlessness, fainting, joint discomfort or back pain? *(Explain).*

Do you take any prescription medicaion? *(Indicate how long you have been taking each medication).*

Could you be pregnant or are you trying to conceive?

☐ Yes ☐ No

Are you a smoker?

☐ Yes ☐ No

CARDIOVASCULAR HEALTH

Have you had any medical consultation regarding your heart? *(Please detail).*

Indicate if any of the below apply.

- ☐ Chest pain/tightness
- ☐ Heart/stroke condition
- ☐ History of high blood pressure
- ☐ History of high cholesterol
- ☐ Male, age > 45yrs
- ☐ Post menopausal
- ☐ Current blood pressure >140/90
- ☐ Currently have high cholesterol
- ☐ Female, age > 55yrs
- ☐ Family history of heart disease
- ☐ Circulatory problems
- ☐ Liver/thyriod/kidney condition

Is there anything not listed above that you feel is relevant to mention?

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HOW DO YOU CURRENTLY FEEL

Do you have any aches/pains at the moment that may prevent you from exercising? *(Please detail).*

How healthy do you feel? (1= least, 10= greatest):		How strong do you feel? (1= least, 10= greatest):	
How energetic do you feel? (1= least, 10= greatest):		How fit do you feel? (1= least, 10= greatest):	

Are there any other special conditions or previous injuries not listed here that may affect your training?

PROPOSED EXERCISE SCHEDULE

This is an initial outline of what you can realistically devote in terms of your time to achieving your fitness goals.
You can optionally leave this section blank and your trainer will assist you to complete it during your consultation.
30 to 60 minutes a day 3-5 times per week is a good general guide.

Day	**Availability** (early/morning, afternoon, evening)	**Proposed session times**	**Duration** (30, 45 or 65 mins)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Target number and duration of sessions each week:			

DISCLAIMER

I acknowledge that participating in this physical activity is done at my own risk. I accept all risks and release the trainer from any liability associated with my participation in this physical activity. I acknowledge that participating in this physical activity may involve a risk of injury. I attest to being physically capable of participating in physical activity and a qualified medical practitioner has not advised me otherwise. I am not aware of any medical condition, injury or impairment that will be detrimental to my health if I participate in this physical activity. I will advise my trainer immediately if I become aware of any medical condition, injury or impairment in the future.

I certify that I am 18 years or older, have read and fully understand this document. Or, as parent/guardian, I agree to the above for myself and on behalf of the participant.

I agree to pay all fees as and when due and adhere to the cancellation policy which is that any cancellations within 24 hours of the time of the session will be charged and forfeited.

(If this form is returned by email, please check the acceptance box below to indicate your approval of these conditions).

Client signature:		◯ I accept	Date:
Parent/guarian signature: *(If under 18)*		◯ I accept	Date:

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Establishing Your Goals

SETTING "SMART" GOALS

Goals should always be: S - Specific M - Measurable A - Achievable R - Realistic T - Time Bound

Instructions
1. **Goal.** Briefly describe each goal/objective.
2. **Measurement.** How will the goal/objective be evaluated? *(Use quantitative measures such as percentages, kilograms and centimeters)*
3. **Importance.** Rank the goal as Essential, Important, or Desirable as follows:
   Essential - the reason you are training *Important - necessary for training satisfaction* *Desirable - an asset to aim towards*
4. **Timeframe.** When should the goal be met or accomplished by.

Some common short and longer term goals are shown below as examples to guide your goal setting:

Goal:

Measurement:

Importance: ☐ *Essential* ☐ *Important* ☐ *Desirable* Timeframe:

Goal:

Measurement:

Importance: ☐ *Essential* ☐ *Important* ☐ *Desirable* Timeframe:

Goal:

Measurement:

Importance: ☐ *Essential* ☐ *Important* ☐ *Desirable* Timeframe:

Goal:

Measurement:

Importance: ☐ *Essential* ☐ *Important* ☐ *Desirable* Timeframe:

Goal:

Measurement:

Importance: ☐ *Essential* ☐ *Important* ☐ *Desirable* Timeframe:

Goal:

Measurement:

Importance: ☐ *Essential* ☐ *Important* ☐ *Desirable* Timeframe:

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