New Client Questionnaire

YOUR CONTACT DETAILS

Name

FIRST

LAST

Email

Phone

Address

STREET ADDRESS

ADDRESS LINE 2

CITY

STATE / PROVINCE / REGION

ZIP / POSTAL CODE

COUNTRY

LIFESTYLE

Describe your job.

Do you consider your job physically challenging or active?

How many hours do you spend in front of a computer?

On a scale of 1 to 10 (1 = no stress, 10 = a lot of stress), please rate the amount of stress in your career.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

On a scale of 1 to 10 (1 = no stress, 10 = a lot of stress), please rate the amount of stress in your personal life.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What time do you usually go to bed at night and wake up in the morning?

Are there any other notes about your lifestyle that you would like to share?

21 IMPORTANT QUESTIONS ABOUT YOUR HEALTH HISTORY

If you answer "yes" to any of these questions, please provide details such as date of occurrence, frequency, intensity, amount, etc.

Do you suffer from back pain?

- Yes
- No

If yes, please give details.

Are you sensitive to touch/pressure in any area?

- Yes
- No

If yes, please give details.

Do you have tension, numbness or pain in a specific area?

- Yes
- No

If yes, please give details.

Do you experience frequent headaches?

- Yes
- No

If yes, please give details.

Are you pregnant?

- Yes
- No

If yes, please give details.

Have you ever given birth?

- Yes
- No

If yes, please give details.

Do you have high blood pressure?

- Yes
- No

If yes, please give details.

Do you have high cholesterol?

- Yes
- No

If yes, please give details.

Have you ever had surgery?

- Yes
- No

If yes, please give details.

Have you ever broken any bones?

- Yes
- No

If yes, please give details.

Do you experience stiff, swollen or painful joints?

- Yes
- No

If yes, please give details.

Do you have difficulty sleeping?

- Yes
- No

If yes, please give details.

Do you experience fatigue or lack of energy?

- Yes
- No

If yes, please give details.

Do you experience cold hands or feet?

- Yes
- No

If yes, please give details.

Have you ever been advised by a physician to avoid any type of exercise?

- Yes
- No

If yes, please give details.

Have you ever been knocked unconscious or suffered a concussion?

- Yes
- No

If yes, please give details.

Do you or does someone in your family have a cardiac condition?

- Yes
- No

If yes, please give details.

Do you have any known allergies?

- Yes
- No

If yes, please give details.

Are you currently taking any medications, not including nutritional supplements?

- Yes
- No

If yes, please give details.

Do you smoke or have you smoked in the past?

- Yes
- No

If yes, please give details.

Do you have any medical issues that have not yet been discussed in this questionnaire?

- Yes
- No

If yes, please give details.

YOUR EXERCISE STATUS

Describe your current exercise routine, if any.

What is the heaviest you have weighed, and how old were you at that time?

What previous fat loss, lean muscle gain, or body improvement treatment(s) have you tried? Please state what and when.

Have you ever had any of the following: physical therapy, chiropractic, massage, acupuncture, Feldenkrais, rolfing, Alexander technique, Other? Please elaborate.

Have you ever worked with a personal trainer? If so, provide details:

How many days do you have to commit towards exercise (include the approximate number of minutes)?

Are there any areas of your body that you consider “problem areas”?

YOUR NUTRITION & METABOLISM

Have you ever had your metabolism tested?

- Yes
- No

If yes, please give details.

Do you count or track calories?

- Yes
- No

If yes, please give details.

Does a high carb snack or meal, with lots of veggies, bread, toast, cereals, rice, fruits, grains or potatoes as the main food source satisfy or stimulate your appetite? (1 = satisfies, 10 = stimulates)

1 2 3 4 5 6 7 8 9 10

Do you notice that you gain a lot of weight when you eat red meat, or lose weight? Do you look slimmer in the mirror or do your clothes fit easier? (1 = gain weight, 10 = lose weight)

1 2 3 4 5 6 7 8 9 10

Do you constantly look forward to the next meal, frequently thinking about foods and what you want to eat? (1 = yes, 10 = no)

1 2 3 4 5 6 7 8 9 10

What is your appetite like at breakfast? (1 = weaker, 10 = stronger)

1 2 3 4 5 6 7 8 9 10

What is your appetite like at lunch? (1 = weaker, 10 = stronger)

1 2 3 4 5 6 7 8 9 10

What is your appetite like at dinner? (1 = weaker, 10 = stronger)

1 2 3 4 5 6 7 8 9 10

Do higher fat foods and/or higher protein foods such as dark meats, avocados, cream, butter, or coconuts within 1–2 hours of bedtime help you sleep better? (1 = yes, 10 = no)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

If you ate a large salad with some low-fat meat like chicken breast for lunch (versus a higher fat meat like a hamburger patty), how would it affect your productivity the rest of the afternoon? (1 = energetic and satisfied, 10 = tired and hungry)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What about if you ate a steak? (1 = energetic and satisfied, 10 = tired and hungry)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How often do you typically feel the need to eat on an average day? One meal would be a 1, three meals a day would be a 5, while six to seven meals a day would be a 10. (1 = 1-2× including snacks, 10 = 6-7× including snacks)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

How much do you enjoy sour foods like pickles, sauerkraut, or vinegar? (1 = love them, 10 = can't stand them)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

At Thanksgiving or a meal where you eat turkey, assuming all the turkey is moist, if you prefer white meat give yourself a 1, dark meat a 10, and no preference a 5. (1 = white meat, 10 = dark meat)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What is a typical breakfast?

What is a typical lunch?

What is a typical dinner?

Describe your snacking habits in between breakfast, lunch, and dinner:

Describe your pre-workout nutritional habits, if any:

Describe your “during the workout” nutritional habits, if any:

Describe your post-workout or nutritional habits, if any:

Describe all nutritional supplements you are currently using. Include multivitamins, sport supplements, electrolytes, and any special juices, pills, capsules or tablets:

How much water do you drink per day, apart from exercise?

How much water do you drink during exercise?

Please describe any known food sensitivities, or intense likes/dislikes:

Do you ever have heartburn, gastrointestinal distress, or stomach problems?

Please describe any religious, ethical, or logistical limitations regarding nutrition (include information about any current nutritional sponsors):

Use the following section to include any additional nutritional notes:

FINAL THOUGHTS – YOUR GOALS

Describe what you truly desire from completing this program. What do you truly desire? Out of your fitness? Out of life? What do you want your body to look like in 1 year? 5 years? In other words, why are you sitting here, taking valuable minutes out of your life to complete this form? What are your specific goals or objectives? Be as honest and specific as possible, describing your dream body, lifestyle, or health. Pour yourself onto the page. Include anything that you feel would be helpful that you haven't yet had a chance to express. All your responses remain completely confidential!

Thanks for taking the time. We can now use this information to help you reach your dreams.