**PRELIMINARY QUESTIONNAIRE:**

Name:

Email:

Phone:

Height:

Weight:

Desired weight (if known):

Desired weight loss or gain per week (if known):

Present Body Fat Percentage (if known):

Desired Body Fat Percentage (if known):

Date of Birth (Month, date, year):

Sex (Male or Female):

Females:

 Pregnant (Yes/No):

 Nursing (Yes/No):

Body Build (Small, Medium, or Large):

Place your thumb and middle finger around your wrist. Small = fingers overlap. Medium = fingers touch. Large = fingers don't touch.

Activity Level (sedentary, moderately active, or very active):

Sedentary = word processor, computer programmer.
Moderately active = waitress, waiter.
Very active = construction worker.

Length of time since last medical check-up:

Any known injuries, illnesses, or medical conditions:

Yes/No - Have you had:

A heart attack or failure?

Heart surgery?

Metabolic disease?

A pacemaker or other heart device?

A heart valve disease or congenital heart disease?

Pulmonary disease?

Stroke?

Coronary artery disease?

Musculoskeletal/Nerve problems?

Yes/No - Do you experience:

Pain in the chest, neck, jaw, or arms?

Shortness of breath with mild exertion?

Palpitations, rapid heart rate, or irregular heart beat?

Shortness of breath when laying flat?

Intermittent claudication / thrombosis?

Ankle swelling?

Heart murmur?

Dizziness?

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

Do you feel pain in your chest when you do physical activity?

In the past month, have you had chest pain when you were not doing physical activity?

Do you lose your balance because of dizziness or do you ever lose consciousness?

Has a doctor ever said your blood pressure was too high?

Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be made worse with exercise?

Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?

Current Medications:

Current Dietary Supplements:

Major Ailments:

Past Surgeries:

Goals:

(Weight Loss, Weight Gain, Fat Loss, Muscle Gain, Energy Increase, Metabolism Increase, Contest/Sports Participation)

Athletic Background (if any):

Current Fitness Level (Beginner, Intermediate, Advanced, Collegiate or National Level, Professional):

How long have you been exercising for:

Current number of workouts per week:

Current number of meals per day:

Number of weight workouts per week:

Number of total sets per body-part:

Number of repetitions per set:

Length of rest between sets:

Number of cardio workouts per week:

Length of cardio workouts:

Types of cardio workouts:

Hours of sleep each night:

Do you want a home-based, gym-based, or combined home and gym workout program?

Foods you like (or wish to emphasize):

Foods you dislike (or need to avoid):

Are you OK with eating chicken, fish, ground turkey, brown rice, rice cakes, green vegetables, grapefruit, apples, nuts, cream of rice, oatmeal, egg whites, lean ground beef, and peanut or almond butter?

List any of the above that you DO NOT like to eat:

**Please keep a food diary for the next 3 days.  Write down everything you eat and drink (the amount along with the time of day).**

*The information gathered here is strictly confidential and obtained solely for the purpose of providing a better and more effective individual program. No advice given is intended as or is a substitute for medical advice. No attempt will be made to diagnose or treat any injury, illness, or medical condition. Any exercise or physical activity is associated with the possibility of injury. All such risks are assumed by the participating party. You should consult your physician before following this or any new exercise or diet program.*