CARPE DIEM
PERSONAL TRAINING,INC.

In order to better assess your needs, please fill out this form completely and accurately. This information is essential to developing a program that safely and effectively addresses your goals. All information will be kept confidential.

Name: _____ Date of Birth: __/__/__ Age: _____
Address: _____
Street City State Zip Code
Phone: _____ (h)_____(c)_____ (w)
Best Time of Day to call: _____
Email Address: _____

Occupation:
Employer: _____ Position: _____

Primary Health Care Provider:
Physician's Name: _____ Phone: _____
Address: _____
Street City State Zip Code
Secondary Health Care Provider(s): please list the name and reason for seeing this provider (ob-gyn, psychiatrist, massage therapist, etc.)
Name: _____ Care Provided: _____
Name: _____ Care Provided: _____
Name: _____ Care Provided: _____

Current Height: _____ Current Weight: _____

Emergency Contact Information:
Name: _____ Phone: _____

What are your reasons for participating in a Fitness Program? Please be as specific as you can.

_____
_____
_____
_____
_____

Par Q – Please mark YES or NO to the following:

	YES	NO
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?		
Do you frequently have pains in your chest when you perform physical activity?		
Have you had chest pain when you were not doing physical activity?		
Do you lose your balance due to dizziness or do you ever lose consciousness?		
Do you have a bone, joint, or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e.: diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?		
Are you pregnant now or have given birth within the last 6 months?		
Have you had a recent surgery?		
Do you currently have mercury dental fillings (amalgams)?		

If you marked YES to any of the previous questions, please elaborate below:

_____
_____
_____
_____
_____

Please list any medications or supplements you are currently taking and what you take them for.

_____
_____
_____
_____

When was the last time you took antibiotics?

_____
_____

Fitness History:

1. Please describe your current exercise activity (frequency and duration):

_____
_____
_____

2. What has prevented you from exercising in the past?

_____

3. How many times per week and for what duration would you like to exercise?

_____

4. Please describe your ideal training week: (include activity/specific days/time spent/days off/alone or with others, etc.) Be specific.

_____

_____

_____

_____

Lifestyle Questions:

1. Do you smoke? If yes, how much? _____

2. How much water do you drink in a day? _____

3. Do you drink soda, diet soda or use artificial sweeteners? _____

4. Does your urine have a foul odor after eating asparagus? _____

5. How many times have you had a cold in the last year? _____

6. How often do you experience headaches/migraines? _____

7. Please describe your typical sleep patterns. _____

8. On a scale of 1 – 10, how is your stress level? (1=very low, 10=very high) _____

9. What are your 3 biggest sources of stress?

_____

_____

_____

10. Do you feel that you would benefit from help with your nutrition? Explain.

_____

_____

11. Do you obtain a yearly physical from your doctor? _____