True North Yoga and Fitness

Personal Training Client
Intake Form

Date

Name (Last) (First) (MI)

Address City ST Zip

Email | Date of Birth (MM/DD/YY)

Home Phone | Work/Cell Phone

Occupation

Emergency Contact

Name | Relation

Address City ST Zip

Home Phone | Work/Cell Phone

Physician Information

Physician's Name | Phone

Has your physician referred you to an exercise program? ☐ Yes ☐ No

Have you ever had a Stress Test? ☐ Yes ☐ No If yes, how long ago?

For what reason was this test performed?

Has your physician cleared you to exercise? ☐ Yes ☐ No ☐ No physician comment

Heath History
(Confidential Information)

Please list any medication (prescription or non-prescription) you are taking.

Do you now, or have you had in the past:

	Yes	No	Please explain yes answers
1. History of heart problems, chest pain or stroke			
2. Elevated blood pressure			
3. Any chronic illness or condition			
4. Difficulty with physical exercise			
5. Advice from physician not to exercise			
6. Recent surgery (last 12 months)			
7. Pregnancy (now or within last 3 months)			
8. History of breathing or lung problems			
9. Muscle, joint, or back disorder, or any previous injury still affecting you			
10. Diabetes or thyroid condition			
11. Cigarette smoking habit			
12. Obesity (BMI>30 kg/m^2)			
13. Elevated blood cholesterol			
14. History of heart problems in immediate family			
15. Hernia, or any condition that may be aggravated by lifting weights or other physical activity			

Have you been to an acupuncturist or chiropractor? ☐ Yes ☐ No

Do you use a massage therapist regularly? ☐ Yes ☐ No

Exercise

Do you currently engage in any form of regular exercise? ☐ Yes ☐ No If yes, please specify:

Have you ever participated in a regular exercise program? ☐ Yes ☐ No If yes, please specify:

Have you ever participated in competitive athletics? ☐ Yes ☐ No If yes, please specify:

How much physical exertion is required in your occupation? Please specify:

What is your primary reason for starting an exercise program?

Please list at least three goals you wish to achieve through your personal fitness program, in order of importance:

What activities interest you? (Check all that appeal to you, even if you have never tried them before.)

	Yoga		Walking
	Running/Jogging		Strength Training
	Hiking		Kayaking
	Cross-country Skiing		Elliptical Striding
	Downhill Skiing		Zumba
	Golf		Traditional Aerobics
	Cycling		Rock Climbing
	Stationary Biking		Pilates
	Racquet Sports		Triathlon
	Swimming		Other: ______________________________

Are there any activities in which you do not want to participate?

Are there any other comments or concerns we need to know prior to your starting a personal fitness program?

Lifestyle/Nutrition History

Do you smoke? ☐ Yes ☐ No If you quit, when?

How many hours of sleep do you get per night?

Rate your daily stress levels (1-10)

What three things cause you the most stress?

How do you relieve your stress?

What do you consider a good weight for yourself?

How many times a day do you eat (including snacks)?

How many meals do you eat at home per day?

How many times per week do you eat out (restaurants/fast food)?

Do you do the cooking at home? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No

Do you use salt? ☐ Yes ☐ No

Do you drink coffee, tea or colas? ☐ Yes ☐ No Cups/glasses per day?

Do you take vitamins or supplements? Yes No If yes, please list:

Are you on a special diet now? Yes No If yes, please explain:

Approximately how many 8 oz. glasses of water do you drink per day?

Approximately how many servings of fruit do you eat per day?

Approximately how many servings of vegetables do you eat per day?

What three things do you think you need to work on as far as nutrition is concerned?

Thank you!