

MSU WELLNESS CENTER PERSONAL TRAINING QUESTIONNAIRE

Date: _____
Name: _____
Address: _____
Email: _____
Phone #: _____ Sex: _____ Male _____ Female
Birth Date: _____ Age: _____
Occupation: _____
Physician's Name: _____
Physician's Address & Phone: _____



Please check all days when you would prefer to meet with the trainer:

SUN _____ MON _____ TUE _____ WED _____ THU _____ FRI _____ SAT _____

When do you prefer to exercise with the trainer? (please circle)

Morning Afternoon Evening Specific time _____

Do you prefer a male or female trainer? (please circle)

Male Female No Preference Specific Trainer: _____

FITNESS QUESTIONS

1. How would you rate your experience with exercise? (please circle)

Beginner Intermediate Advanced

2. Are you presently involved in a regular exercise program? If yes, please list activity, duration, frequency, and intensity: _____

3. How active do you consider yourself? (please circle)

Sedentary Lightly Active Moderately Active Highly Active

4. How long have you been in your current fitness routine? _____

5. What are your fitness goals? (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Lose weight/inches | <input type="checkbox"/> Reduce Stress |
| <input type="checkbox"/> Gain weight/muscle | <input type="checkbox"/> Increase energy |
| <input type="checkbox"/> Improve strength | <input type="checkbox"/> Injury prevention |
| <input type="checkbox"/> Improve flexibility | <input type="checkbox"/> Feel better overall |
| <input type="checkbox"/> Improve cardiovascular fitness | <input type="checkbox"/> Improve muscle conditioning |
| <input type="checkbox"/> Other (Please Specify) | |

6. What are your personal barriers that could impede your progress towards accomplishing your goals?

7. How do you plan to overcome the barriers?

8. How would you characterize your life? (please circle)

Highly Stressful Moderately Stressful Low in Stress

9. How would you like to be motivated during your training sessions? _____

10. Any additional information you wish to share: _____

1. Do you now or have you ever smoked? ____ Yes ____ No

If you previously smoked, how long did you smoke. How often, and when did you quit? _____

If you currently smoke, how much? _____

2. Do you use alcohol? ____ Yes ____ No

If yes, how much per day? _____ How much per week? _____

3. Do you drink coffee or colas with caffeine? ____ Yes ____ No

If yes, how much per day? _____

4. How would you describe your nutrition habits? (please circle)

Good Fair Poor

5. Please describe your knowledge of nutrition. (please circle)

Good Fair Poor

6. Are you now or have you ever been on a diet? ____ Yes ____ No

If yes, please explain: _____

7. How many meals do you usually eat per day? _____

8. Do you usually eat breakfast? ____ Yes ____ No

9. Do you have any medical conditions for which a physician has ever recommended some restrictions on activity (including surgery)? ____ No ____ Yes

If "yes" please explain: _____

10. Do you have any physical movement restrictions or range of motion discomfort that we should be aware of?

____ No ____ Yes If "yes" please explain:

11. Please indicate any additional medical information that you think is important for us to know about prior to any exercise or fitness testing:

All information provided is accurate to the best of my ability.

Sign

Date