Client Profile & Health History

Date _____/_____/_____

Name ______________________ Spouse ______________________

Birthdate ____/____/____ Age __________

Address ____

Email ______________________ Phone ______________________

Primary Care Physician ____
(Name) (Office) (Phone Number)

Emergency Contact ____
(Name) (Phone Number)

Please indicate if you have any of the following:

	Yes	No	Explain
Advice from a physician NOT to exercise			
Difficulty with physical exercise			
Heart problems, chest pain, or stroke			
History of heart problems in immediate family			
High Blood Pressure			
High Cholesterol			
Asthma / Breathing / Lung Problems			
Cigarette / Cigar / Pipe smoking habit			
Pregnancy (now or within last 3 months)			
Recent surgery (last 12 months)			
Diabetes or Thyroid Condition			
More than 20 lbs over your ideal weight			
Any chronic illness or condition			
Muscle, tendon, joint, or back disorder (see below)			
Arthritis			
Bursitis			
Foot Injuries (past / present)			
Knee injuries (past / present)			
Hip injuries (past / present)			
Shoulder injuries (past / present)			
Fatigue			
Anxiety			
Hernia or any condition that may be aggravated by lifting weights			
Currently taking any medications			
Over 35 years old (men) / 40 years old (women)			
Any other limiting factor, not listed above			

If you answered "yes" to any of the above Risk Factor questions, seek medical clearance from your physician prior to beginning this exercise program.

Client signature ______________________________ Date:_____/_____/_____

Interests and Goals

(Please Circle)

Lose Body Fat	Weight	Less Stress
Reduce Inches	Muscle	Posture
Tone/Firm Up	Strength	Group Classes
Energy	Cardio	Program Design
Stamina	Flexibility	Education
Rehabilitation	Mobility	Accountability
Healthy Living	Nutrition	Other

Present Physical Condition

Rate your physical condition: (horrible) 1 2 3 4 5 6 7 8 9 10 (outstanding)

Current Weight:___________

Your Weight 2 Yrs. Ago:_________

Employment: Active_________ Sedentary_________

Outside Activites and Recreation:

Married: Yes No

Children: Yes No

Habit Tracker

			How Much/How Often
3 Meals per day	Yes	No	________________
Fast Food	Yes	No	________________
Alcohol	Yes	No	________________
Restaurant Food	Yes	No	________________
Coffee	Yes	No	________________
Smoke	Yes	No	________________
Snacks	Yes	No	________________
Soft Drinks	Yes	No	________________
Warch TV	Yes	No	________________
Supplements/Vitamins	Yes	No	________________
8 Hrs. of Sleep Daily	Yes	No	________________
8-8oz. Glasses of Water Daily	Yes	No	________________

Six Month Goals

Arms	*Gain*	*Reduce*	*Maintain*
Legs	*Gain*	*Reduce*	*Maintain*
Waist	*Gain*	*Reduce*	*Maintain*
Chest	*Gain*	*Reduce*	*Maintain*
Heart Rate	*Gain*	*Reduce*	*Maintain*
Hips	*Gain*	*Reduce*	*Maintain*
Back	*Gain*	*Reduce*	*Maintain*

Lifestyle

Occupation/Type of Work_________________________________ Company___________________

What type of hours do you put in?____________________________

What is your stress level? Low Moderate High

What is your personality type? Laid Back Aggressive Moody Hot Tempered

What is the activity level of your day (not including exercise)? Light Moderate Heavy

Describe your overall daily energy level. Very Low Low Medium High Very High

Current Exercise Program—Resistance Training

How many days per week are you currently resistance training?______ Where?_____________

Current Exercise Program—Aerobic/Cardiovascular Training

How many days per week are you currently doing aerobic exercise?______ Where?_____________

Please list any sports/recreational activities you participate in, and how often.

Please list your food choices from the last 24 hours.

Breakfast____

Mid-morning____

Lunch____

Afternoon____

Dinner____

Evening____

What are your primary health and fitness goals? (Please define as specifically as possible with deadlines)

1.____

2.____

3.____

What has prevented you from reaching these goals in the past?

How many days per week are you willing to REALISTICALLY commit to an exercise program? ______

What days could you potentially schedule workouts? (Please check all that apply)

__M __T __W __Th __F __ Sa

How much time per workout?____________________

What time(s) of the day would you be able to workout? (Please check all that apply)

__Early Morning __Late Morning __Lunchtime __ Afternoon __ Evening

Have you ever utilized the services of a personal trainer? Yes No

If yes, who and how long?

If no, why?

What brought you to the decision to partner with Kinetic Edge?

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate profile.

____ ______________________________

Client’s signature Date

CONFIDENTIALITY NOTICE: The information recorded within this document will remain confidential between client and trainer.