painted lady fitness

**Ashley Silversides**
Certified Personal Trainer,
Yoga Teacher & Tattoo Artist Wellness

# Client Information

## Basic Info

Name: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Date of Birth: _____ Age: _____
Occupation: _____
Height: _____ Weight: _____

## Contact In Case of Emergency

Name: _____ Home Phone: _____ Cell Phone: _____
Relation: _____

## Family Physician

Name: _____ City: _____ Phone Number: _____

# Personal Health & Medical History

1. Please check the conditions that are appropriate for you:

☐Allergies
☐Anemia
☐Angina (chest pain)
☐Arthritis (where)
☐Asthma
☐Bronchitis
☐Cancer (type)
☐Cholesterol High
☐Cholesterol Low
☐Depression
☐Diabetes (type)
☐Dizziness/Fainting
☐Emphysema
☐Epilepsy/Seizures
☐Heart Condition
☐Hernia
☐Hypertension
☐Inner Ear Problems
☐Joint Problems
☐Kidney Disease
☐Lung Disease
☐High or Low Blood Pressure
☐Obesity
☐Osteoporosis
☐Pregnancy
☐Respiratory Condition
☐Severe Headache
☐Stroke
☐Thyroid Problems
☐Ulcer
☐Visual Depth/Perception Problems
☐Other

2. Have you ever had muscle, bone or joint illness or injury (including the back)? If yes please explain. ☐**Y** ☐**N**

3. Do you currently have muscle, bone or joint problems that may affect your activity level? ☐**Y** ☐**N**
Please explain concerns or complications: _____

4. Do you have any other activity restrictions? ☐**Y** ☐**N**
If yes, please explain: _____

5. Do you suffer from any of the following: numbness, tingling and/or swelling? ☐**Y** ☐**N**
If yes, which, and explain: _____

6. Do you currently have any medical conditions for which you see a physician regularly? ☐**Y** ☐**N**

7. Do you currently work with any practitioner, chiropractor, massage therapist, osteopath or other? ☐**Y** ☐**N**
If so, who, and for what condition: _____

8. Have you ever been to a physician who has referred you to an exercise program? ☐**Y** ☐**N**

9. Have you ever had a stress test? ☐**Y** ☐**N**
If yes, how long ago & why was the test preformed? _____

10. Has your body weight shifted more then 10 lbs. in the last year? ☐**Y** ☐**N**
If yes, please explain: _____

11. How would you evaluate your fitness over the past six months?
☐**None** ☐**Minimal** ☐**Average** (3 times week) ☐**Significant** (5+ times a week)

12. Do you feel as though you are in good health? ☐**Y** ☐**N**
Please explain: _____

13. Are you currently taking any medications? ☐**Y** ☐**N**
If yes, please list medication and condition: _____

14. Do you take medication for allergies? ☐**Y** ☐**N**
If yes, please list medication required: _____

15. Have you had surgery in the past two years? ☐**Y** ☐**N**
If yes, please explain_____

16. Have your father or brother had a heart attack or heart surgery before the age of 55? ☐**Y** ☐**N**

17. Have your mother or sister had a heart attack or heart surgery before the age of 45? ☐**Y** ☐**N**

18. Do you have regular medical/physical checkups? ☐**Y** ☐**N**

## Exercise & Fitness History

1. Do you currently engage in any form of regular exercise? ☐**Y** ☐**N**
If yes, please specify: _____

2. Have you ever participated in a regular exercise program? ☐**Y** ☐**N**

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If yes, please specify: _____

3. Have you ever-participated in competitive athletics? ☐**Y** ☐**N**
If yes, please specify: _____

4. Any exercises or activities that you don't want to participate in? _____

5. When was the last time that you had consistent exercise in your life? _____

6. What exercises do you or have you enjoyed in the past?
   a) _____
   b) _____
   c) _____
   d) _____

7. Are you physically active 3 or more times a week? ☐**Y** ☐**N**

8. Is exercise something you are doing for you or others? ☐**MYSELF** ☐**OTHERS**
Please explain: _____

## Health & Fitness Goals

**1. Below are several fitness goals, check which apply to you**

| | | |
|---|---|---|
| ☐Feel Healthier | ☐Improve Muscle Tone | ☐Increase Aerobic Fitness |
| ☐Lose Weight | ☐Improve Flexibility | ☐Recover From Injury |
| ☐Gain Weight | ☐Improve Sport Performance | ☐Prevent Injury |
| ☐Look Better | ☐Increase Energy Level | ☐Prevent Stress |
| ☐Improve Sleep | ☐Reduce Muscle Fat | |
| ☐Improve Strength | ☐Increase Endurance | |

2. Now in order of importance list your top 5 goals
   i. _____
   ii. _____
   iii. _____
   iv. _____
   v. _____

3. Your most important goal is & why? _____

## Nutrition Information

1. What do you consider a good weight for yourself? _____

2. What is the most that you have ever weighed? _____

3. How many meals do you eat a day? _____

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4. Number of meals that you eat at home? _____

5. How many times a day do you eat including snacks? _____

6. Do you do the cooking at home? _____

7. Do you drink coffee, tea or soda? ☐**Y** ☐**N**
How many a week & of which: _____

8. Do you drink alcoholic beverages? ☐**Y** ☐**N**
How many a week: _____

9. Do you use salt? ☐**Y** ☐**N**

10. Do you currently follow a diet plan? ☐**Y** ☐**N**
If yes, please explain: _____

11. How many servings of fruit do you eat a day? _____

12. How many servings of vegetables do you eat a day? _____

13. How many servings of grains and cereal do you eat a day? _____

14. How many servings of meat and nuts do you eat a day? _____

15. Do you follow a strict diet? ☐**Y** ☐**N**

16. Do you make a conscious effort to eat healthy? ☐**Y** ☐**N**
Please explain: _____

17. How many glasses (8oz) of water do you drink a day? _____

18. What portion size are your meals?
☐**Small** (palm size) ☐**Medium** (plate size) ☐**Large** (more than one serving)

19. What snacks do you chose? _____

20. Do you consider your meals balanced? ☐**Y** ☐**N**
Please explain: _____

21. Do you read food labels? ☐**Y** ☐**N**

22. How many meals a day do you eat sitting at a table? _____

23. How many meals a day do you eat on the run? _____

24. Do you eat breakfast daily? ☐**Y** ☐**N**
If yes, what do you have: _____

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25. Do you take vitamins or supplements? ☐**Y** ☐**N**
If yes, please list:

- _____
- _____
- _____
- _____

## General Info/Lifestyle & Work

1. Do you have stress in your life? ☐**Y** ☐**N**
If yes, is it ☐**Low** ☐**Moderate** ☐**High**

2. Are you a happy person (0 not happy -10 very happy)? _____

3. On a scale of 0-10 (0 low- 10 high) what's your motivation level? _____

4. How many hours of sleep do you get a night? _____

5. Which best describes your activity while at work?
☐**Primary Inactive** (desk job)
☐**Lightly Active** (nurse)
☐**Heavily Active** (labor)

6. Do you presently smoke or have you quit in the past year? ☐**Y** ☐**N**
If yes, please explain: _____

7. Do you use recreational drugs? ☐**Y** ☐**N**

**Other Information you would like to add:**

_____

_____

## Client:

By signing this form, I certify that I have fully disclosed all pertinent information in an honest and truthful manner.

**Signature:** _____ **Date:** _____

## Personal Trainer:

By signing this form, I certify that I have asked for and understand the pertinent information required for me to make an informed decision.

**Signature:** _____ **Date:** _____

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