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)

_____ Lose weight/inches
_____ Gain weight/muscle
_____ Improve strength
_____ Improve flexibility
_____ Improve cardiovascular fitness
_____ Other (Please Specify)

_____ Reduce Stress
_____ Increase energy
_____ Injury prevention
_____ Feel better overall
_____ Improve muscle conditioning

_____

_____

_____

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