## MSU WELLNESS CENTER PERSONAL TRAINING QUESTIONNAIRE

| Email: Sex:MaleFemale  Birth Date: Age:  Occupation:  Physician's Name:  Physician's Address & Phone:  Please check all days when you would prefer to meet with the trainer:  | MINO?                  |  |                   |   |                      | ::                  | Date: _ |  |  |  |
|---|------------------------|--|-------------------|---|----------------------|---------------------|---------|--|--|--|
| Email:  | STATE                  |  |                   |   |                      | e:                  | Name:   |  |  |  |
| Email:  | Wellness Cente         |  |                   |   |                      | ress:               | Addres  |  |  |  |
| Birth Date:   |                        |  |                   |   |                      |                     |         |  |  |  |
| Occupation:   |                        | Female   | Male              | Sex:                                    |                      | ne #:               | Phone   |  |  |  |
| Physician's Name:   |                        |  | ge:               | Age                                     |                      | Date:               | Birth D |  |  |  |
| Physician's Address & Phone:  Please check all days when you would prefer to meet with the trainer:  SUN MON TUE WED THU FRI SA  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 Reduce Stress Gain weight/muscle Injury prevention Improve strength Injury prevention Improve cardiovascular fitness Improve muscle conditioning        |                        |  |                   |   |                      | ıpation:            | Occupa  |  |  |  |
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| Improve flexibility Feel better overall Improve cardiovascular fitness Improve muscle conditioning  |                        | Increase energy  |                   |   | eight/muscle         | Gain w              |         |  |  |  |
| Improve cardiovascular fitness Improve muscle conditioning  |                        |  |                   |   | -                    |                     |         |  |  |  |
|   | ioning                 | <del></del>  |                   | fitness                                 |                      |                     |         |  |  |  |
| <del></del> , , , , , , , , , , , , , , , , ,   | TOTHING                | improve musere co  |                   | 111111111111111111111111111111111111111 |                      |                     |         |  |  |  |
|   | ioning                 | <del></del>  |                   | fitness                                 | ve cardiovascular f  | Improv              |         |  |  |  |
|   |                        |  |                   |   |                      |                     | 6       |  |  |  |
| 6. What are your personal barriers that could impede your progress towards accomplishing your goals?  | ng your godis?         | ogress towards accomp  | eue your progre   | s triat could impe                      | i personal parriers  | . vvnat are you     | ъ.      |  |  |  |
|   | <del></del>            | <del></del>  |                   |   |                      |                     |         |  |  |  |
|   |                        |  |                   |   |                      |                     |         |  |  |  |

| H   | low would you characterize your life? (please circle)   |  |  |  |  |
|---|---|--|--|--|--|
|   | Highly Stressful Moderately Stressful Low in Stress   |  |  |  |  |
|   | How would you like to be motivated during your training sessions?   |  |  |  |  |
| Any additional information you wish to share: |   |  |  |  |  |
|   |   |  |  |  |  |
|   | 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?   |  |  |  |  |
|   | Do you use alcohol? Yes No  |  |  |  |  |
|   | If yes, how much per day? How much per week?  |  |  |  |  |
|   | Do you drink coffee or colas with caffeine? Yes No  |  |  |  |  |
|   | If yes, how much per day?   |  |  |  |  |
|   | How would you describe your nutrition habits? (please circle)   |  |  |  |  |
|   | Good Fair Poor  |  |  |  |  |
|   | Please describe your knowledge of nutrition. (please circle)  |  |  |  |  |
|   | Good Fair Poor  |  |  |  |  |
|   | Are you now or have you ever been on a diet? Yes No   |  |  |  |  |
|   | If yes, please explain:   |  |  |  |  |
|   | How many meals do you usually eat per day?  |  |  |  |  |
|   | Do you usually eat breakfast? Yes No  |  |  |  |  |
|   | Do you have any medical conditions for which a physician has ever recommended some restrictions on activity |  |  |  |  |
|   | (including surgery)? NoYes  |  |  |  |  |
|   | If "yes" please explain:  |  |  |  |  |
|   |   |  |  |  |  |
|   | Do you have any physical may ment restrictions or range of mation discomfort that we should be aware of?    |  |  |  |  |
|   | Do you have any physical movement restrictions or range of motion discomfort that we should be aware of?    |  |  |  |  |

| 11.    | 11. Please indicate any additional medical information that you think is important for us to know about pri |     |  |  |  |  |
|--------|---|-----|--|--|--|--|
|        | exercise or fitness testing:  |     |  |  |  |  |
|        |   |     |  |  |  |  |
|        |   |     |  |  |  |  |
|        |   |     |  |  |  |  |
|        |   |     |  |  |  |  |
| All ir | nformation provided is accurate to the best of my ability   |     |  |  |  |  |
| Sign   |   | ate |  |  |  |  |