Client Name:_____ **Date:**_____

Phone #:_____ **D.O.B.:** _____ **Gender:** _____

E-mail address:_____ **Occupation:**_____

Address:_____

Emergency Contact:_____ **Phone #:**_____

HEALTH HISTORY

Y	**N**	**1. Are you currently taking any medications? If Yes, please describe**_____
Y	**N**	**2. Do you have diabetes or a thyroid condition?**
Y	**N**	**3. Has your doctor ever said that you have an elevated level of blood cholesterol?**
Y	**N**	**4. Are you now, or have you been pregnant in the last three months?**
Y	**N**	**5. Have you had recent surgery? Describe.**
Y	**N**	**6. On a scale of 1-10 (1-poor 10-elite) how would you rate your present fitness level?** _____
Y	**N**	**7. Do you smoke?**

ACTIVITY RELATED QUESTIONS

1. **The single most important goal for me to attain through exercise would be…**
2. **How many times per week will you commit to working out? What time of day is ideal and for how long?**
3. **List in order of priority your short term fitness goals (4-6wks)**
4. **List in order of priority your long term fitness goals (3-12mths)**
5. **What do you believe your fitness strengths and weakness are? (i.e. favorite/least favorite exercises, strongest/weakest body part(s))**