

# CLIENT INFORMATION QUESTIONNAIRE

Please complete and return to Therapeutic Trainers Network via Fax, Mail or E-mail listed below at least 2 days prior to your first scheduled session.

All information received on this form will be treated as **strictly confidential**. Please fill out the forms **completely and accurately**. This information is essential to helping your trainer develop a program that addresses your needs, goals and interests and is safe and effective.

Name: _____				Date of Birth: ___/___/___			Age: _____	
Address: _____								
Street		City		State		Zip Code		
Phone: _____ (h) _____ (o) _____ (cell)								
Email address: _____								
Occupation: _____								
Emergency Contact: _____				Relationship: _____				
Phone Number: _____								
Physician's Name: _____				Physician's Phone: _____				
Physician's Address: _____								
Street		City		State		Zip Code		
Therapeutic Trainers Network will send information regarding your physical exercise program to your physician unless you request otherwise.								

Please provide 48 hours notice if you need to cancel or reschedule your Personal Training appointment.

**Therapeutic Trainers Network**  
P.O. Box 19329  
Portland, OR 97280  
Phone: 503-246-0082  
Fax: 503-246-0240  
info@therapeutictrainers.com  
www.therapeutictrainers.com

# PAR-Q FORM

Please mark YES or No to the following:

YES NO

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?

Do you frequently have pains in your chest when you perform physical activity?

Have you had chest pain when you were not doing physical activity?

Do you lose your balance due to dizziness or do you ever lose consciousness?

Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)?

Are you pregnant now or have given birth within the last 6 months?

Have you had a recent surgery?

If you have marked YES to any of the above, please elaborate below:

Do you take any medications, either prescription or non-prescription, on a regular basis? YES NO

What is the medication for? \_\_\_\_\_

How does this medication affect your ability to exercise or achieve your fitness goals?  
\_\_\_\_\_

## Lifestyle Related Questions

1) Do you smoke? YES NO If yes, how many? \_\_\_\_\_

2) Do you drink alcohol? YES NO If yes, how many glasses per week? \_\_\_\_\_

3) How many hours do you regularly sleep at night? \_\_\_\_\_

4) Describe your job: Sedentary Active Physically Demanding

5) Does your job require travel? YES NO

6) On a scale of 1-10, how would you rate your stress level (1=very low, 10=very high)? \_\_\_\_\_

7) List your 3 biggest sources of stress:

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

8) Is anyone in your family overweight? Mother Father Sibling Grandparent

9) Were you overweight as a child? YES NO If yes, at what age(s)? \_\_\_\_\_