Primary Training Objective

Question 1 Please list THREE in order of personal importance:

_____ Improved Strength	_____Improve Cardiovascular Fitness	_____Fat Loss
_____General Fitness	_____Build Muscle	_____Improved Function
_____Body Building	_____Tone-Up	_____Rehabilitation
_____ Post-Rehabilitation	_____Reduce Back Pain	_____Improve Sports Performance
_____Injury Prevention	_____Improve Flexibility	_____Reduce Stress
_____Increase Energy		

Question 2 Specify sport(s) and/or other training objectives that are not listed

Question 3 Are you currently involved in any exercise program (circle one)? **YES** **NO**

Question 4 If yes, please list how long and what type of exercises

Question 5 What kinds of sports do you enjoy most? Please list.

Medical Information (where applicable please circle “yes” or “no”)

Question 1 Do you suffer from back pain? **YES** **NO**

Question 2 Are you sensitive to touch/pressure in any area? **YES** **NO**
If yes, where?

Question 3 Do you have tension or soreness in a specific area? **YES** **NO**
If yes, where?

Question 4 Do you have numbness or stabbing pains anywhere? **YES** **NO**
If yes, where?

Question 5	Do you experience frequent headaches?	**YES NO**
Question 6	Do you have high blood pressure?	**YES NO**
Question 7	Do you have high cholesterol?	**YES NO**
Question 8	Are you epileptic?	**YES NO**
Question 9	Have you ever had surgery?	**YES NO** If yes, what for and when?
Question 10	Have you ever broken any bones?	**YES NO** If yes, which bones and when?
Question 11	Do you experience stiff, swollen or painful joints?	**YES NO** If yes, please describe in more detail:
Question 12	Do you have difficulty sleeping?	**YES NO**
Question 13	Do you experience fatigue or lack of energy?	**YES NO**
Question 14	Have you ever been advised by a physician to avoid any type of exercise?	**YES NO**
Question 15	Have you ever been knocked unconscious or suffered a concussion. If yes, please state how many times and the date(s).	**YES NO**
Question 16	Do you (or someone in your family) have a cardiac condition?	**YES NO**
Question 17	Do you have any allergies? If yes, please list:	**YES NO**
Question 18	Do you smoke?	**YES NO**
Question 19	Do you live with a smoker?	**YES NO**

Question 20	Please list any medications you are currently taking:
Question 21	Have you ever had any of the following - physical therapy, chiropractic, massage, acupuncture, Other? Please elaborate.
Question 22	How much time do you spend in a seated position?
Question 23	How many hours do you spend in front of a computer?
Question 24	What time do you usually go to bed at night?
Question 25	What time do you usually wake in the morning?
Question 26	How many meals do you eat each day? List the number and time of day you usually eat these meals.