Exercise Progression

Questionnaire

Date_______________

Name____ Birthday____________________

Address____ Phone________________(work)

City____ Zip________________________

E-Mail____ Phone_________________(cell)

Emergency Contact____ Phone_____________________

Co-Signer (if under the age of consent)/Relation to client

Name____ Birthday____________________

Address____ Phone______________________

City____ Zip________________________

Medical History

Injuries (past/present)____

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Symptoms____

Medical Concerns ____

Surgeries____

Medications____

Pain Level Score out of 10 ____ If higher than a 3, do you have a Dr.'s approval for exercise? Y/N

Personal Info/History

Hrs sleep/ night _____
Hrs work/ day _____
Home cooked meals/wk _____
Vegetable servings/day _____
Fruit servings/day _____
Meat servings/day _____

Meals/day _____
Digestion: good/sluggish/irritable
Cups of coffee/day _____
Ounces of water/day _____
Alcoholic beverages/day _____
Cigarettes/day _____

Measurements (we take here)

Weight _____
Body Fat_____ BMI____
Arms (L)____ (R)_____
Thighs (L)____ (R)_____
Calves (L)____ (R)_____
Chest ____ Waist _____