



CLIENT INTAKE FORM

PERSONAL INFORMATION

FULL NAME: _____ DATE OF BIRTH: _____ GENDER: M / F

ADDRESS: _____

PHONE NUMBER: _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____ PHONE NUMBER: _____

HEALTH AND MEDICAL HISTORY

1. Do you have any chronic health conditions? (e.g., diabetes, heart disease) _____
2. Are you currently on any medications? If yes, please list. _____
3. Do you have any allergies? (e.g., medications, food, environmental) _____
4. Have you had any surgeries or hospital stays in the past? If yes, please detail. _____
5. Do you currently experience any pain or discomfort? If yes, please specify. _____

LIFESTYLE QUESTIONS

1. Occupation and daily activity level: _____
2. Current exercise routine (if any): _____
3. Dietary habits: _____
4. Smoking/Alcohol Consumption: _____
5. Stress levels (low, medium, high): _____
6. Sleep patterns and quality: _____

FITNESS GOALS

1. What are your primary fitness goals? (e.g., weight loss, muscle gain, endurance training) _____
2. What motivates you to achieve these goals? _____
3. What has prevented you from reaching these goals in the past? _____
4. Do you have any specific event or date you are training for? If yes, please specify. _____

AVAILABILITY

Preferred days and times for training sessions: _____

CONSENT AND AGREEMENT

1. Do you agree to follow the safety instructions and guidance provided by your personal trainer? _____
2. Do you consent to periodic evaluations to assess progress? _____
3. Please read and sign the liability waiver attached.