



**body
incarnate**
personal training
....for women

I want to help you achieve your goals!

Please complete the following "getting to know you" questions so that together we can turn your health and fitness dreams into realities!

YOUR NAME: _____

YOUR CONTACT PH. NUMBERS: _____

YOUR POSTAL ADDRESS: _____

WHEN IS YOUR BIRTHDAY? _____

Which of the following goals are important to you?

I want to get **fitter**
I want to get **stronger**
I want to **lose weight**
I want to **tone up**
I want a **faster metabolism**
I want **more energy**

I need rehabilitation / pain relief for my:
Back
Knees
Shoulder /s
Other _____
I have a specific sporting goal

HOW important is it for you to achieve these goals?

Urgent Very important Important If it happens, it happens!

WHEN do you want to achieve these goals? Do you have a specific time frame?

HOW many days a week have you set aside to achieve your goals? _____

CIRCLE WHICH days of the week are best for you to include exercise? M Tu W Th F Sa Su

PLEASE describe your exercise characteristics:

I am self motivated

I find exercise easier to stick to if I have a partner

I find exercise easier with regular motivation

I need constant motivation

ARE you currently exercising? YES NO SOMETIMES

TELL me the ways to exercise that you LOVE! _____

TELL me the ways to exercise that you HATE! _____

PLEASE TURN OVER TO COMPLETE THE MEDICAL QUESTIONS

The Medical Questions -

Please complete the following questions. ALL information is held in strict confidence.

I MUST know ALL of your existing medical conditions. It is your responsibility to complete these questions before participating in our exercise programs. It is also your responsibility to inform me if your medical or physical condition changes.

I WANT TO MAKE SURE OUR TIME TOGETHER IS SAFE AS WELL AS FUN!

Do you have any medical conditions you think may prevent you from exercising?

YES NO I AM NOT SURE.

Description: _____

Do you have or do any of the following conditions exist in your family history?

Asthma Diabetes High or low blood pressure High Cholesterol
 Heart Problems Epilepsy Dizziness Chest Pain Arthritis
 Osteoporosis

Any other conditions you think I should know about: _____

Do you have any joint problems, aches, pains or injuries – past or present?

Ankles Knees Hips Back Shoulders Neck
 Elbows Wrists Others – describe _____

Do you take any pills / tablets / medication / medicines?

YES NO Please describe: _____

When was your last Doctors visit, how often do you go and what for? _____

Are you or have you recently been pregnant? _____

I am happy to recommend that you consult with your Dr. before participating in any training sessions. Please advise me immediately if your medical condition should change, and we will complete this paperwork again.

Thank you for helping me, to help you achieve your health & fitness goals – safely.



Names and Numbers of persons who can be contacted in case of emergency:

If I am unable to contact the above persons, in the case of Emergency, do you want me to call an ambulance?

YES NO

PLEASE inform me of any medical condition that may prevent you from exercising. Please be aware that I will do everything to ensure that your exercise program is safe and effective, however you are choosing to exercise at your own risk, and I do not take responsibility if you choose to participate in the training program. You must take responsibility of your own body.

YOUR FULL NAME _____

SIGNATURE _____ **DATE** _____

BODY INCARNATE PERSONAL TRAINING Client Questionnaire