Fit To Fly, LLC
Personal Training Health and Wellness Questionnaire

Please print legibly or circle where applicable.

Personal Information:

Name: _____ Gender: Male / Female / Other

DOB: ____/____/_____ Pronouns: (He/Him) (She/Her) (They/Them)

Other: _____

Address: _____
(#) (Street) (Apt/Ste)

_____
(City) (State) (Zip)

Phone #: ( ) _____ - _____ Phone Type: Cell / Home / Work

Email: _____

Preferred Contact Method: Text / Email / Phone Call

Emergency Contact

Name: _____ Phone # ( ) _____ - _____

Relation of emergency contact:

Spouse/Partner Parent Friend Other: _____

Medical History:

What was the date of your most recent physical? _____

Has your doctor ever said that you have a heart condition, or any other condition, and should only do physical activity recommended by a doctor?	Yes	No
Do you feel chest pain when you do physical activity?	Yes	No
In the past month, do you have any chest pain at rest?	Yes	No
Do you ever lose your balance because of dizziness or lose consciousness?	Yes	No
Do you have a bone or joint problem that could be made worse by physical activity?	Yes	No
Is your doctor currently prescribing anything for your blood pressure or heart condition?	Yes	No
Do you know of any other reason why you should not do physical activity?	Yes	No
Do you have or have you ever had any diagnosed medical conditions? If yes, please list in the space below this table.	Yes	No
Have you suffered any injuries? If yes, please explain in the space below this table.	Yes	No
Have you ever had physical therapy? If yes, please explain in the space below this table.	Yes	No
Are you currently on any medications? If yes, please list them and any side effects that you experience.	Yes	No
Are you pregnant now, or have you given birth in the last six months?	Yes	No
Have you had a recent surgery? If yes, please explain in the space below this table.	Yes	No

Additional Information:

Lifestyle:

What is your current level of exercise? (Please include how often and what type of exercise you currently do)

How many hours of sleep do you get in a typical night? _____

How much water do you drink in a day, on average? _____

What is your daily nutrition like?

What is your occupation? _____

Do you smoke? If so, what, and how often? _____

Do you drink alcohol? If so, how many drinks per week? _____

Please rate the following levels of stressors on a scale of 1-10 (1 being hardly any, 10 being the most stress that you can imagine):

- Physical stress: _____
- Emotional/Spiritual stress: _____
- Mental stress: _____

Fitness:

What are some of your short and long-term fitness goals? Be as specific as possible.

Short term (in the next 3-6 months):

Long Term (6 months- 2years):

What type of exercise do you enjoy, or what exercise are you interested in trying?

Why did you decide to try personal training?

How many days per week can you commit to training? _____

What type of fitness equipment do you have access to?

Have you worked with a personal trainer before? If so, what were the results?

What do you expect/hope to get out of training?

What are some obstacles, behaviors, or activities that have slowed your progress in reaching your fitness goals in the past?

Thank you.