# Personal Training Intake Form

**Date:**

**Name:**

**Date of Birth:**

**Height:**

**Weight:**

**Address:**

**Contact Number:**

**E-mail:**

Do you have any diagnosed health problems?

- [ ] Yes
- [ ] No

If yes, what are they?

Are you taking any medications for them?

- [ ] Yes
- [ ] No

If yes, what are they?

Are you currently injured? Have you been injured before?

- [ ] Yes
- [ ] No

If yes, what are they?

Are you following a specific diet (e.g., low-fat, low-carb, vegan, high-protein)?

- [ ] Yes
- [ ] No

If yes, please specify what you typically eat or drink.

How many hours do you regularly sleep at night? _____

How many glasses of water do you consume daily? _____

Do you drink caffeine?

☐ Yes

☐ No

If yes, how many cups daily? _____

Do you drink alcohol?

☐ Yes

☐ No

If yes, how many glasses daily/weekly? _____

Do you consume carbonated beverages?

☐ Yes

☐ No

If yes, what beverage/s and how many daily/weekly? _____

Do you smoke?

☐ Yes

☐ No

If yes, what do you smoke, and how many daily/weekly? _____

**FITNESS**

How would you describe your daily stress level?

How would you describe your daily activity/fitness level?

How do you stay active? What activities do you do for strength and/or cardio? How often do you do these activities?

What are your fitness goals?

How many sessions do you want weekly? What are your preferred training days and times?

Do you have any trainer preferences? _____