### **Personal Training Client Information Form**

To ensure that we create the best possible training plan tailored to your needs, please complete the following form with your basic information and medical history. All information is confidential.

**Personal Information**

* **Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Gender:** ☐ Male ☐ Female ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **State/Province:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Zip/Postal Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

* **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Relationship to You:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Health & Medical History**

1. **Do you have any pre-existing medical conditions?**☐ Yes ☐ No
If yes, please list them:
2. **Are you currently taking any medications?**☐ Yes ☐ No
If yes, please specify:
3. **Do you have any allergies or sensitivities?**☐ Yes ☐ No
If yes, please list them:
4. **Have you had any surgeries or major injuries in the past?**☐ Yes ☐ No
If yes, please describe:
5. **Do you have any of the following conditions?** (Check all that apply)
☐ Heart disease
☐ High blood pressure
☐ Asthma or breathing issues
☐ Diabetes
☐ Joint problems (e.g., knees, hips, etc.)
☐ Back pain
☐ Seizures or neurological conditions
☐ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. **Are you pregnant or planning to become pregnant?**☐ Yes ☐ No

### **Exercise Readiness**

1. **Do you currently exercise regularly?**☐ Yes ☐ No
If yes, what type of exercise do you do, and how often?
2. **Have you ever participated in strength training or other structured exercise programs before?**☐ Yes ☐ No
If yes, please describe your experience:

### **Additional Information**

1. **Do you have any specific fitness goals?** (e.g., weight loss, muscle gain, increase flexibility, improve endurance, etc.)
2. **Is there anything else you would like me to know about your fitness history or health?**