MaxResultX Personal Training Client Intake Form

Date:_____

Name:_____ **Date of Birth:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Phone: _____ **Alt Phone (Cell/Work)** _____

Email Address:_____

Emergency Contact:_____ **Phone:**_____

Height:_____ **Weight:**_____ **Goal Weight:**_____ **Sex(M/F)**_____

Lifestyle:

Occupation:_____ **Sedentary, Active, Physically Demanding?**

Does your job require frequent long distance travel by car or plane? (Yes/No)_____

Rate your daily stress level (1:very low, 10:very high)_____

How many hours do you regularly sleep at night?_____

Do you smoke? Yes_____ **No**_____ **If yes, how often?**_____

Activity Level:

What are your fitness goals?_____

Rate your current fitness level, 1-10 (1: low, 5: average 10: high)_____

What activities do you do for strength exercises? (weights, pilates, calisthenics)

_____

How many days a week?_____

What activities do you do for aerobic exercises? (running, walking, tennis, group classes)

_____

How many days a week?_____

Desired personal training time and days:_____

Number of sessions per week:_____ Trainer preference: (M/F)_____

Referred by:_____

Nutrition:

Please list what you typically eat and drink for the following meals and around what time?

Breakfast:

_____

_____

_____

_____

Lunch:

_____

_____

_____

Dinner:

Snacks:

How many glasses of water do you consume per day?_____

Do you drink caffeine? Yes_____ No_____ Type_____ # of cups per day_____

Do you drink alcohol? Yes_____ No_____ # of glasses per day/week_____

Do you drink soft drinks? Yes_____ No_____ Diet_____ Regular_____ # per day/week_____