Client Information Form

Basic Info:

Name:_____Date_____

Physical Address:_____

City_____State_____Zipcode_____

Email Address:_____

Phone number Cell:_____ work:_____

Employer: _____Type of work:_____

Gender:_____Age:_____DOB:_____

Height: _____ Current Weight: _____ Goal Weight: _____

What are your specific goals:

_____

Specific time a day that works best for exercise: _____

Current workout
schedule_____

_____

What are some of your biggest obstacles when trying to stick to a workout program and nutrition plan?

_____

_____

Medical History:

Are you under medical supervision? _____

Medications_____

Supplements_____

Surgeries/Injuries_____

Check all that apply:

Food Allergies_____

Asthma _____

Respiratory/pulmonary_____

Diabetes_____

Epilepsy_____

Osteoporosis_____

Cardiovascular

High Blood Pressure_____ Heart Disease_____

Hyperlipidemia_____ High Cholesterol_____

Stroke_____ Heart Attack_____

Hypertension_____ Gout_____

Lifestyle:

Stress Level 1-10_____

Energy Level 1-10_____

Caffeine intake/daily_____

Activity level Sedentary_____ Moderate _____Active_____

Do you drink Alcohol? _____ Drinks per week _____

Cigarette or tobacco? _____How much _____

How often do you eat out?_ _____when?_____

Favorite restaurants:_____

_____

Current Diet

Time_____Breakfast_____
_____
_____
_____
_____

Time____Snack_____
_____
_____
_____

Time_____Lunch_____
_____
_____
_____

Time_____Snack_____
_____
_____
_____

Time_____Dinner_____
_____
_____
_____
_____
_____

Time____ Late night
snack_____
_____

5 favorite Proteins	5 favorite carbs/grains	5 favorite veggies	5 favorite Fats	5 favorite treats