



OPERATOR FITNESS

P.O. Box 781
Temple City, CA 91780 USA
626.230.3137 • OpsFit1@gmail.com

CLIENT INTAKE FORM

All information received on this form will be kept confidential. Please fill out completely and accurately.

Client Info:

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Physicians Name: _____ Phone: _____

PLEASE allow 24 hour notice if you need to cancel or reschedule your scheduled personal training appointment.

Personal Info:

What made you decide to do personal training? _____

What is your primary goal? _____

What are your favorite activities? _____

On a scale of 1-10, how would you rate your current fitness level (1=worst, 10=best)? _____



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Health ~ PAR-Q Form Please mark YES or NO to the following:

Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor? _____

Do you feel pain in your chest when you do physical activity? _____

In the past month, have you had chest pain when you were not doing physical activity? _____

Do you lose your balance because of dizziness or do you ever lose consciousness? _____

Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, et cetera)? _____

Are you pregnant now or have given birth within the last six months? _____

Have you had a recent surgery? _____

Do you take any medications, either prescription or non-prescription, on a regular basis? _____

What is the medication for? _____

Do you know of any other reason why you should not do physical activity? _____

If you marked "YES" to any of the above, please explain below:

Lifestyle Related:

Do you smoke? Yes No

If yes, how many per day? _____



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Do you drink alcohol? Yes No
If yes, how much per week? _____
How many hours do you regularly sleep at night? _____

Describe your job:

Sedentary Active Physically Demanding

Does your job require you to travel? Yes No

On a scale from 1-10, how would you rate your stress level? (1=low, 10=high) _____

List your 3 biggest sources of stress:

- a. _____
- b. _____
- c. _____

Do you regularly use the services of a massage therapist? Yes No

Chiropractor? Yes No

Is anyone in your family overweight? _____

Were you overweight as a child? _____

Developing Your Fitness Program:

How often do you take part in physical exercise?

- a. _____ times per week
- b. _____ minutes in duration

If your participation is lower than you would like it to be, what are the reasons?

Lack of interest Illness/Injury Lack of Time
Other: _____



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What activities are you presently involved in?

Cardio / Movement _____

Strength Training / Pilates _____

Stretching / Yoga _____

Sports and/or outdoor activities _____

Other _____

Which area would you like the most assistance with? _____

Realistically, how often would you like to exercise? _____ times per week

Realistically, how much time would you like to spend during each exercise session? _____

Based on your desired and available commitment, how often would you like to see a trainer* to help you achieve your goals?

3xweek 2xweek 1xweek 2xmonth 1xmonth

***DOES NOT APPLY TO ONLINE COACHING PROGRAMS**

What are the best days during the week for you to commit to your exercise program?

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

What are the best times for you to exercise?

Morning Afternoon Evening

If you could design your own exercise program, what would an ideal training week look like? Be specific.



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What would you ultimately like to learn from a trainer/these sessions?

Goal Setting:

How can I help you? Please circle all that apply:

Lose Body Fat Develop Muscle Tone Reduce Stress Rehabilitate an Injury

Nutrition Education Start an Exercise Program Design a More Advanced Program

Sports Specific Training Motivation Fun Training for an Event

Other _____

In order to increase your chances of being successful at achieving your goals, ensure your goals are "SMART":

S = Specific (provide details, how much, how long, etc)

M = Measurable (how will you measure when you've reached your goals)

A = Attainable (be realistic, set smaller goals)

R = Rewards-based (attach a reward to each goal)

T = Time (set specific dates for goals)

Please list in order of priority, the goals you would like to achieve in the next 3-12 months:

- a. _____
- b. _____
- c. _____

How important is it for you to achieve these goals?

Not important Semi-important Very important



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How long have you been thinking about these goals? _____

How will you feel once you have achieved these goals? _____

Where do you rate health in your life?

Unhealthy Average Good

Where does your spouse/significant other/family rate health in their lives?

Unhealthy Average Good

What do you think is the most important thing your trainer can do to help you achieve these goals? _____

List what you feel are the obstacles or potential actions, behaviors or activities that could impede your progress towards accomplishing your goals?

List three methods that you plan to use to overcome these obstacles:

a. _____

b. _____

c. _____

Nutrition:

On a scale from 1-5, how would you rate your nutrition (1=poor, 5=excellent)? _____

How many times throughout the day you eat? _____

Do you skip meals? Yes No Do you eat breakfast? Yes No

Do you eat late at night? Yes No



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What activities do you engage in while eating (TV, reading, etc)? _____

How many 8 ounce glasses of water do you consume daily? _____

Do you have decreased energy throughout the day or changes in mood? Yes No

What kinds of food do you regularly eat? _____

Do you know how many calories you consume in a day? Yes No
If yes, how many? _____

Have you every tracked your food intake (i.e. food diary)? Yes No

Are you currently taking a multi-vitamin or any other supplements? Yes No

How often do you eat out on a weekly basis? _____

Do you do your own cooking? Yes No

Do you do your own grocery shopping? Yes No

Besides hunger, what other reasons do you eat?

Bored Social Stressed Tired Depressed Happy Nervous

Do you eat mostly processed food or freshly prepared food? *Processed Fresh*

Do you eat foods high in fat and sugar? Yes No

Do you eat past the point of fullness? Yes No

Do you prefer salty or sugary foods? *Salty Sugary*

Do you read nutrition labels? Yes No

If so, what do you look at? _____



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List three areas that you would like to improve in the nutrition area:

- a. _____
- b. _____
- c. _____

Miscellaneous:

Please list anything else that you may feel is a concern or information that has not been disclosed that may be pertinent to being physically active or working with a personal trainer.

**THE BEST COMPLIMENT I CAN RECEIVE IS YOUR
REFERAL OF ANOTHER POTENTIAL CLIENT!**



@OpsFit1