CLIENT READINESS AND NUTRITIONAL PAR-Q FORM

Below you will find a series of questions to be filled out prior to starting your Personal Training and Nutrition Coaching. Please complete the entire Par-Q and bring it with you to your Client Consultation.

The following information is used to determine a client's current health and fitness level, to identify any risk factors a client may have before starting a fitness program and to determine a client's current nutritional habits. The information gathered informs the trainer if there is a need for a physician's medical clearance before designing a customized training and nutritional program.

BASIC INFORMATION

Client's Name: _____

Date: _____

Date of Birth: _____

Address: _____

Phone: _____

Mobile: _____

Email: _____

Physician Name: _____

Physician's Phone: _____

Physician's Fax: _____

MEDICAL HISTORY

Have you had or do you presently have any of the following conditions? Please check all that apply.

- ☐ Rheumatic fever
- ☐ Recent operation
- ☐ Edema (swelling of ankles)
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Injury to back or knees

- ☐ Seizures
- ☐ Lung disease
- ☐ Heart attack
- ☐ Fainting or dizziness
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Orthopnea (the need to sit up to breathe comfortably)
- ☐ Paroxysmal (sudden or unexpected attacks)
- ☐ Nocturnal dyspea (shortness of breath at night)
- ☐ Shortness of breath at rest or with mild exertion
- ☐ Unusual fatigue or shortness of breath with activity
- ☐ Chest pains
- ☐ Palpitations or tachycardia (unusually high or rapid heartbeat)
- ☐ Intermittent claudication (calf cramping)
- ☐ Pain, discomfort in the chest, neck, jaw, arms or other area
- ☐ Known heart murmur
- ☐ Temporary loss of visual activity or speech or short-term numbness or weakness in one side, arm(s) or leg(s) of your body
- ☐ Other

Please explain checked items:

_____

_____

_____

FAMILY HISTORY

Have any of your immediate family members (parent, sibling or children) experienced the following conditions? Please check all that apply and note at what age the condition occurred.

- ☐ Heart attack
- ☐ Heart operation
- ☐ Congenital heart disease

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Other major illnesses

Please explain checked items:

_____

_____

_____

LIFESTYLE INFORMATION

1. What is your present occupational position?

_____

2. What is the activity level at your job?

- ☐ None (seated work only)
- ☐ Moderate (light activity such as walking)
- ☐ High (heavy labor, very active)

3. Does your job involve shift work?

- ☐ Yes
- ☐ No

4. If you follow a regular schedule at work, do you work days, afternoons and/or evenings?

_____

_____

5. How often do you travel?

- ☐ Rarely
- ☐ A few times a year
- ☐ Few times a month
- ☐ Weekly

6. Please list the physical activities you participate in outside of the gym or work?

_____

_____

EXERCISE HISTORY

1. Have you ever worked with a trainer before?

☐ Yes

☐ No

2. Date of your last physical examination performed by a physician.

_____

3. Do you participate in a regular exercise program?

☐ Yes

☐ No

If *yes*, please describe your current routine in detail (types of exercise and amount of time with each).

_____

_____

_____

_____

GOAL SETTING

1. List in order of precedence your current health and fitness goals.

_____

_____

_____

_____

_____

2. Do you have a specific timeframe for achieving a specific goal? If *yes*, please specify:

_____

_____

_____

_____

_____

3. Check what type of progress is more important to you?

☐ Immediate progress that is less easily maintained.

☐ Maintainable progress that may not be as rapid.

DIETARY INTAKE AND NUTRITIONAL HABITS

1. Do you follow or have you recently followed any dietary intake instructions?

☐ Yes

☐ No

If *yes*, please describe your nutritional habits.

_____

_____

If *no*, how do you feel about your nutritional habits.

_____

_____

2. If you are currently using any nutritional supplements, please list them (as well as the doses you are taking).

_____

_____

3. How many times per week do you shop for groceries?

☐ None

☐ 1-2

☐ 2-3

☐ 4-5

☐ 5-6

☐ 7+

4. How many meals do you eat in restaurants and/or fast food places per week?

☐ None

☐ 1-2

☐ 2-3

☐ 4-5

☐ 5-6

☐ 7-8

☐ 8-9

☐ 9-10

☐ 10+

5. If you have any known food allergies, please list them below.

_____

_____

_____

6. Are there any foods to which you are particularly sensitive to or which cause excess gas, bloating, stuffiness or congestion?

_____

_____

7. Please provide a three-day dietary record (see attached at bottom of form). Be sure that these records represent the last few months of your dietary habits. If you recently dramatically changed your diet, please indicate how you were eating prior to your changes. If your current habits have been in place for less than a month please record your habits prior to the most recent month.

OTHER

1. Is there anything that has not been mentioned above that your trainer should be aware of?

_____

_____

_____

_____

_____

FOOD RECORD

FOOD ITEM/ BRAND	**TIME OF DAY**	**QUANTITY** (*tblspn, tspn, cups, quarts, oz, lbs*)	**INGREDIENTS**
1.			

2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
FOOD ITEM/ BRAND	**TIME OF DAY**	**QUANTITY** *(tblspn, tspn, cups, quarts, oz, lbs)*	**INGREDIENTS**

1.			
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