Par Q, Release, Lifestyle Questionairre / Health History / Meal Plan Form

CLIENT INFORMATION / Par Q
Before Working with any Client- Client fills out this page

All information received on this form will be treated as strictly confidential. Please fill out the forms ***completely and accurately***. This information is essential to helping your trainer develop a program that addresses your needs, goals and interests and is safe and effective.

Name:_____ Date of Birth____/____/____ Age:_____
M D Y

Address:_____
Street City State Zip Code

Phone: _____(cell) Cell phone provider _____

_____(work) _____(home)

Email address: _____ Occupation:_____

Emergency Contact Name & Number:_____Relationship:

Phone Number:_____ Physician's Name:_____

Physician's Phone:_____Address:_____
City State Zip Code

PAR-Q FORM

Please mark YES or No to the following:	**YES**	**NO**
Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	_____	_____
Do you frequently have pains in your chest when you perform physical activity?	_____	_____
Have you had chest pain when you were not doing physical activity?	_____	_____
Do you lose your balance due to 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, etc.)?	_____	_____

1. **How did you hear about us?** Please check that which applies.
□Brochure □Word of Mouth □Health & Fitness Magazine □Downtowner Magazine Ad □Walk or Drive by
□Live close □Received Mailer or Newsletter □South Bluffs Fitness Center □Our Website □Trolley Tour
□Trainer □Other:_____

2. **If you were referred to us, who told you about our services?**

3. **Why did you choose to train with Energy Fitness instead of another organziation?**
Please check that which applies.
□Location □Personal Trainers □Cost □Customer Service □Word of Mouth □Programs □Other:_____

4. **How far do you live from our training studio**?_____ **Work from studio**?_____

5. **Which newspaper(s) do you read**?

6. **Which local magazine (s) do you read?**

7. **What would cause you to discontinue training with Energy Fitness Training?**

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552 South Main
Memphis, TN 38103
901-523-BFIT (2348)
Cell: 901-870-7799
www.EnergyMmemphis.com

Release of Liability

1. In consideration of being allowed to participate in the personal fitness training activities and programs of ENERGY FITNESS and to use its facilities, equipment and services, in addition to the payment of any fee or charge, I do hereby forever waive, release and discharge ENERGY FITNESS and its officers, agents, employees, representatives, executors and all others acting on their behalf from any and all claims or liabilities for injuries or damages to my person and/or property, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf, arising out of or connected with my participation in any activities, programs or services of ENERGY FITNESS or the use of any equipment at various sites, including home, provided by and/or recommended by ENERGY FITNESS.

2. I have been informed of, understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment, is a potentially hazardous activity. I also have been informed of, understand and am aware that fitness activities involve a risk of injury, including a remote risk of death or serious disability, and that I am voluntarily participating in these activities and using equipment and machinery with full knowledge, understanding and appreciation of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation in these activities or use of equipment or machinery. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in the exercise activities, programs and use of exercise equipment. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise equipment. I acknowledge that either I have had a physical examination and have been given my physician's permission to participate or I have decided to participate in the exercise activities, programs and use of equipment without the approval of my physician and do hereby assume all responsibility for my participation in said activities, programs and use of equipment.

4. I understand that ENERGY FITNESS providing and maintaining an exercise/fitness program for me does not constitute acknowledgment, representation or indication of my physiological well-being or medical opinion relating thereto.

Participant Signature _____ **Participant – Printed Name** _____ **Date:** _____

Trainer's Signature: _____

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Are you taking any medications or drugs or supplements? YES NO

1. **If YES, please list medication, dose and reason:**

Medication:_____ Reason:_____
Medication:_____ Reason:_____
Medication:_____ Reason:_____
Medication:_____ Reason:_____
Use the back for more space

2. **Does your physician know you are participating in this exercise program?** Yes No

3. **Do you now, or have you had in the past**:

	Yes	No
History of heart problems, chest pain or stroke		
Increased blood pressure		
Any chronic illness or condition		
Difficulty with physical exercise		
Advice from physician not to exercise		
Recent surgery (last 12 months)		
Pregnancy (now or within last 3 months)		
History of breathing or lung problems		
Muscle, joint or back disorder, or any previous injury still affecting you		
Diabetes or thyroid condition		
Cigarette smoking habit		
Contagious Disease		
Increased blood cholesterol		
History of heart problems in immediate family		
Hernia, or any condition that may be aggravated by lifting weights		
Do you ever feel faint or have dizzy spells		
Arthritis		
Epilepsy		
Anemia		
Hypoglycemia		
History of eating disorder		

4. Please explain any "yes" answers below.

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1. **Are you currently undergoing treatment from any of the following?**

   a. Physiotherapist b. Massage Therapist c. Accupuncturist d. Chiropractor e. Other_____

2. **Is anyone in your family overweight? (circle all that apply)**

   Mother Sibling Father Grandparent Other_____

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3. **Are you a cigarette smoker**? Yes No If yes, how many per day?

☐ **Previously a cigarette smoker?** Yes No If Yes, when did you quit?

How many years have you smoked or did you smoke before quitting? _____

did you smoke (Circle one): Cigarettes Cigars Pipe

4. **Please Rate Your Daily Stress Levels (select one):**

□ Low	□ Moderate	□ High but I enjoy the challenge	□ High: sometimes difficult to handle	□ High: often difficult to handle.

5. ☐ **Do you drink alcoholic beverages?** Yes No

How many units of alcohol do you consume per week: _____ (see Alcohol Units Calculator/table below)

Type of Drink	Units
½ pint of beer	1
1 glass of wine	1
1 pub measure of spirits (Gin, Vodka etc.)	1
1 can of beer	1.5
1 bottle of strong lager	2.5
1 can of strong lager	4
1 bottle of wine	7
1 liter bottle of wine	10
1 bottle of fortified wine (port, sherry etc.)	14
1 bottle of spirits	30

6. **On a scale of 1 to 10, how would you rate your nutrition?** (1=very poor 10=excellent)_____

7. **List 3 areas of your nutrition you would like to improve:**

   1. 2. 3.

Fitness History:

8. **When were you in the best shape of your life?** _____

9. **Did you ever participate in any sports?** Yes No If yes, what?_____

10. **What is anything, stopped you in the past?** _____

11. **On a scale of 1 to 10, how would you rate your present fitness level?** _____

12. **What do you think the most important thing your Personal Trainer can do two help you achieve your fitness goals?**

Thank you for answering this questionairre. It will help in the development of your fitness program and overall wellness.

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First Name: _____Last Name: _____ Age:_____ Birth Date:_____ (mm/dd/yyyy)

E-mail: _____ Height: _____ (inches)

Current weight:_____ (pounds) Goal weight: _____

Gender: male female, If you are a female, are you lactating or pregnant? Yes or No

What are your personal health & fitness goals? circle your answer below

1. Weight loss (designed to decrease body fat with minimal loss of lean body tissue)
2. Maintain (designed to maintain current body composition & develop good eating habits.)
3. Weight Gain (designed to increase lean body mass with minimal increase in body fat.)

Weight LOSS per week goal (circle your answer) ½ pound, 1 pound, 1.5 pounds, 2 pounds

Weight gain per week goal (circle your answer) ½ pound, 1 pound, 1.5 pounds, 2 pounds

Body Type - Please review the following statements. Circle the answer below which best describes you?

Type 1: I can eat anything I want and not gain weight. I have a very hard time gaining weight.

Type 2: I can lose or gain weight by adjusting my activity level and eating habits.

Type 3: I find it very heard to lose weight. I gain weight very easily and have to watch everything I eat.

Profession / Lifestyle : Accurately rate your professional activity level?

1. Sedentary 2. Moderately Active 3. Active 4. Very Active

Do you currently have any of the following medical conditions? Yes (mark any that apply) or No

Heart disease, liver disease, pancreatic disease, anemia, kidney disease, hypoglycemic, diabetes, hypertension

Other:

FAMILY HISTORY Does anyone in your immediate family have any of the following medical conditions?
Yes (mark any that apply) or No

Heart disease, liver disease, pancreatic disease, anemia, kidney disease, hypoglycemic, diabetes, hypertension
Other:

How many minutes of exercise and what type do you do each week? Example: I run a 6.0 mph pace 3 times per week for 30 minutes. I circuit train …….., I weight lift- vigorous effort 45 minutes 2 times / week

(For best weight loss results, do not add any Weekly Exercise activities. Selections will add additional calories to the daily recommended total. Inaccurate estimations in activities ma yield poor weight loss results)

MEAL TYPES - Circle A FEW PREFERENCES - WE WILL CHOOSE BEST FIT FOR YOU
:

energy booster	healthy aging	heart healthy	low carb	low carb American
low carb fast food	low carb Italian	low carb Mexican	low cholesterol	low fat
on the the go	teen scene	lean body builder	performance	
low glycemic	Gluten free	meterianian		

Special needs:	Gluten free	Kosher	Lactose intolerant	Organic low carb
Organic low fat	Vegan	Vegetarian / low fat	Wheat free / low fat	

Disease prevention (check only if you want a diet centered around below choices)

Breast cancer	Cancer prevention (general)	Heart disease	Osteoporosis (bone health)
Stable blood sugar	Stroke prevention		