PERSONAL TRAINING
PRE-QUESTIONNAIRE

Last Name: _____ First Name: _____

Gender: ☐ Female ☐ Male ☐ Other Age: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Chose your preference of trainer:

☐ Female ☐ Male
☐ No Preference

Chose your preference of location:

☐ Gleneagles Community Centre
☐ West Vancouver Community Centre

Check the box, for preferred days/times you wish to train with your trainer:

☐ Morning ☐ Monday ☐ Thursday
☐ Afternoon ☐ Tuesday ☐ Friday
☐ Evening ☐ Wednesday ☐ Saturday

List your current activities:

List your top three goals:

Please read carefully and answer each question honestly:	YES	NO
1. Has your doctor ever said that you have a heart condition OR high blood pressure ?	☐	☐
2. Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	☐	☐
3. Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months?	☐	☐
4. Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	☐	☐
5. Are you currently taking prescribed medications for a chronic medical condition?	☐	☐
6. Do you currently have any bone, joint, or soft tissue problem that could be made worse by becoming more physically active?	☐	☐
7. Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐