SWEET MOMENTUM
FITNESS

Comprehensive Client Information Sheet

Name: Date:

INSTRUCTIONS
This is your comprehensive client information sheet, in which we will ask you to provide some relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual fitness program for you. Please answer all questions in the most accurate manner possible while being as concise as possible. If you are uncomfortable with answering a particular question, feel free to leave it blank.

DISCLAIMER
Please recognize the fact that it is your responsibility to work directly with your physician before, during, and after seeking fitness consultation. As such, any coaching from Sweet Momentum Fitness is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

PART 1: BASIC INFORMATION

Email: Age: Date of Birth:

Address:

City: State: Zip:

Telephone (cell): Telephone (other):

What do you do for a living?

What is the activity level at your job? (check appropriate answer)

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

Contact in Case of Emergency: Relationship to You:

Emergency Contact's Telephone: How did you hear about us?

PART 2: GOALS

Given the following goals, please rank them in order of importance, with 1 being most important and 8 being least important.

Improved health	Improved endurance	Increased strength	Sport-specific*
Fat loss	Increased muscle mass	Increased power	Weight gain

Other goals not listed above:

*Please provide the sport or athletic event for which you are training:

Do you have a specific timeline for achieve a specific goal? If so, please specify:

Select which type of progress is more important to you:

◯ Immediate progress that's less easily maintained ◯ Maintainable progress that may not be as rapid

Why are your goals important to you? What would be the good things about realizing your goals? Another way to think about this: If you could make these changes immediately, by magic, how might things be better for you?

Do the people with whom you spend each day (at work or at home) support your health and fitness goals?

◯ Yes, most of them do
◯ About half do and half don't
◯ No, most of them don't

PART 3: EXERCISE INFORMATION

Are you currently exercising regularly (at least 3x per week)?

If you answered YES, please describe.

How long have you been consistently exercising without a break?

If you answered NO, have you ever been on a consistent exercise plan (at least 3x per week)?

If yes, how long ago was this and how long did it last?

PART 4: MEDICAL AND HEALTH INFORMATION

Do you have any health concerns, medical issues, or injuries that we need to be aware of? If yes, please describe.

Do you know of any movements that irritate your body or cause you pain? If yes, please explain.

Are you taking any medication or supplements right now? If so, which ones and why?

Are you a current cigarette smoker? If yes, how many packs do you smoke a day?

How long have you been smoking?

Are you an ex-smoker? How many years did you smoke? How many packs a day?

When did you quit?

Have you used chewing tobacco or smoked cigars/pipe within the last 15 years?

PART 5: LIFESTYLE/NUTRITION INFORMATION

How many meals and snacks do you eat per day (on average)? meals snacks

Do you eat a lean protein source at every meal?

Do you eat at least 5 servings of vegetables a day?

Do you consume calorie-containing beverages such as soda/pop, sweetened teas, coffees, or juices?

Do you drink at least 100 ounces of water a day?

Do you include starchy carbohydrates such as potatoes, bread, pasta, pastries, etc., frequently throughout the day (more than 2 servings)?

Do you regularly eat processed foods such as candy, frozen meals, chips, etc.?

Do you ever find yourself mindlessly eating or feeling overly full after eating?

Are you frequently hungry or fighting cravings throughout the day?

Do you consume more than 3 alcoholic beverages a week?

Do you get at least 7 hours of good sleep a night?

Do you eat at restaurants or order takeout more than 3 times per week?

Rate your stress level, on average, using a 1-10 scale

What are your energy levels during the day? (scale of 1-10)

MISCELLANEOUS INFORMATION

Please share your most frequent health, nutrition, or physique complaints and/or dissatisfactions, and any other information you think might be relevant to your program design.