Here's a printable copy of the on-line intake wizard. Just in case you want to have a few copies on-hand for those times you might not have access to the Internet.

Some trainers like to provide their clients with a copy to fill out at home.

We believe the best practice for using the Intake Wizard is to complete the Wizard on-line with your client. This allows you to ask follow-up questions, and gain a more in depth knowledge of your clients physical condition and their goals.

We know you'll get great results using this proven process!

The BodyEvolver team.

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Contact Information	
Name	
Email	
Gender	
Height	
Birthday	
Address	
Mobile	
Home	
Work	
Client's Hopes and Dreams	

Consult your physician before starting any physical activity program.

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Consent Waiver

I, _____ herby voluntarily give consent to engage in a fitness test and a physical activity program. I understand that the cardiovascular fitness test will involve progressive stage of increased effort and that at any time I may terminate the test and activity for any reason. I understand that during some tests I may be encouraged to work at maximal effort and that at any time I may terminate the test or activity for any reason.

I understand that there are certain changes that may occur during the exercise test. They include abnormal blood pressure, fainting, disorders of heart beat and very rare instances of a heart attack. I understand that every effort will be made to minimize problems by preliminary examination and observation during the testing.

I understand that I am responsible for monitoring my own condition throughout the testing, and should any unusual symptoms occur I will cease my own participation and inform the test administrator of the symptoms. Unusual symptoms include, but are not limited to: chest discomfort, nausea, difficulty breathing, and joint or muscle injury.

Also in consideration of being allowed to participate in the fitness tests, I agree to assume all risks of such fitness testing and hereby release and hold harmless the trainer who performs these tests and their agents and employees from any and all health claims, suits, losses or causes of action for damages, for injury or death, including claims for negligence, arising out of or related to my participation in the fitness assessment or fitness program.

I have read the foregoing carefully and I understand my consent. I have been advised to consult my physician before starting any physical activity program. Any questions which may have occurred to me concerning the informed consent have been answered to my satisfaction.

Client _____ Witness: _____

Date _____ Date: _____

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Comprehensive PAR-Q

Name: _____

Date: _____

☐ ☐	Yes No	Has your doctor ever told you that you have heart trouble?
☐ ☐	Yes No	Do you currently have diabetes?
☐ ☐	Yes No	Are you male 40 years or older, or female 50 years or older?
☐ ☐	Yes No	Have you had pains in your heart or chest?
☐ ☐	Yes No	Do you at times feel faint or have spells of severe dizziness?
☐ ☐	Yes No	Do you have asthma, emphysema or bronchitis?
☐ ☐	Yes No	Do you currently have thyroid problems?
☐ ☐	Yes No	Have you had any of the following: Shortness of breath especially upon exertion; heart palpitations; leg cramps during walking; or persistent swelling around the ankles?
☐ ☐	Yes No	Has a doctor ever told you about bone or joint problems such as arthritis that has been aggravated by exercise or might be made worse with exercise?
☐ ☐	Yes No	Are you pregnant?
☐ ☐	Yes No	Has a doctor ever told you that your blood pressure was too high?
☐ ☐	Yes No	Have your parents, brother, or sisters suffered from heart disease before the age of 55?
☐ ☐	Yes No	Are you currently a cigarette smoker or have you smoked within the last 6 months?
☐ ☐	Yes No	Has your doctor told you that your cholesterol level is too high?

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Family History
Have either of your parents, or any siblings experienced any of the following conditions?

☐	Heart Attack at Age_____	☐	High Blood Pressure At Age____	☐	Heart Operation
☐	Blood Lipid Disorder	☐	Congenital Heart Disease	☐	Diabetes

Medical History
Have you had, or do you have any of the following conditions?

☐	Rheumatic Fever	☐	High Blood Pressure	☐	Seizures
☐	Fainting Or Dizziness	☐	Shortness Of Breath	☐	Heart Murmur
☐	Short-Term Numbness on One Side, Arm or Chest	☐	Temporary Loss of Visual Acuity or speech	☐	Intermittent Claudication (Leg Cramping)
☐	Palpitations or Tachycardia	☐	Osteoporosis	☐	Recent Operation
☐	Back or Knee Injury	☐	Lung Disease	☐	Diabetes
☐	Chest Pains	☐	Fatigue	☐	Edema
☐	Low Blood Pressure	☐	Hypoglycemia	☐	Hyperglycemia
☐	Heart Disease	☐	Arthritis	☐	High Cholesterol
☐	Asthma	☐	Breathing Difficulties	☐	Thyroid Condition

Blood Pressure _____ Resting Heart Rate_____

Depression Scale
Where do you rate yourself?

☐	I typically do not feel sad.	☐	I feel sad less than half the time.	☐	I feel sad more than half the time.	☐	I feel sad nearly all the time.

On a Scale Of 1 (Low) to 10 (High) Please Rate Your Current Stress Level _____

Other Conditions & Comments

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Your Goals & Fitness Interests
What do you want to achieve with personal training?

☐	Weight Loss	☐	Reduce Stress	☐	Sport Specific Training
☐	Flexibility	☐	Overall Wellness	☐	Increased Energy
☐	Reduce Body Fat	☐	Rehabilitation	☐	Motivation
☐	Improve Physical Strength	☐	Healthier Heart	☐	Reduce Risk Of Disease
☐	Improve Cardiovascular Health	☐	Improve Mobility / Stability	☐	Improve Balance & Coordination
☐	Stop Smoking	☐	Quit Drinking	☐	Improve Sleep Quality
☐	Improve Posture	☐	Streamline Workout	☐	Exercise More Regularly
☐	Improve Eating Habits	☐	Strengthen Bones	☐	Lower Cholesterol
☐	Reduce Prescription Drug Use	☐	Gain Muscle	☐	Tone & Firm

Other Goals & Comments

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Limiting Factors
Do you have any specific current or former injuries, limiting conditions, previous surgeries or chronic / regular pain in any of the following areas that may affect your ability to exercise?

☐	Neck	☐	Shoulders	☐	Arms
☐	Lower Back	☐	Hips	☐	Knees
☐	Hands	☐	Feet		

Please provide details or other information.

Please list any medications you currently use which might affect your heart rate, blood pressure or affect your ability to exercise.

Exercise And Personal History

Are you currently exercising on a regular basis?		How many times per week?	
Do you strength train?		How many times per week?	
Do you cardiovascular exercise?		How many times per week?	

Which type of cardio do you enjoy the most?

What type of exercise routine has worked for you in the past?

Are there any specific fitness activities you dislike?

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Have you ever worked out with a personal trainer?					
Please describe your experience with your previous personal trainer.					
How would you describe your current eating habits?					
☐	Very Good	☐	Pretty Good	☐	Just OK
☐	Needs Improvement	☐	Poor		
Weekly grocery spending $_____		How often do you shop for groceries?			
Weekly restaurant spending $_____		How often do you eat out?			
Monthly supplement spending $_____		Do you frequently skip meals?			
Food Allergies?					
Please describe any dramatic weight gain or loss.					
Do you often feel stressed?		How many alcoholic beverages do you consume per week?			
Do you take a multivitamin?		How many cigarettes do you smoke per day?			
How many hours of sleep do you get per night?		How would you describe your energy level?			
How many glasses of water do you drink per day?		How often have you used antibiotics over the last 12 months?			

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Personal Lifestyle Summary
What is your occupational life like? How do you spend the majority of your day?
Typically how active are you most days? Name some of your daily activities.
Are you very active on your personal time or in your home life?
What sports exercise or physical activities do you enjoy the most?
Do you have any issues or considerations of which you want to inform your trainer?
How do these elements of your life impact your goals? (Positive Or Negative)

Environment:	**People:**
Home	Family
Work	Friends

Personal Lifestyle Summary (Continued)

Do you have solid support for your goals and desires? Are there family members or friends who can support your effort to improve your health?
What has contributed to your fitness level becoming what it is today?
What factors have limited your success thus far?
Please describe any health or nutrition supplements you consume regularly.
In one year I would like to accomplish….

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_____ plans to engage in a scientifically based health, fitness and nutrition program designed to support optimal health. An aerobic exercise and resistance training program will be designed based on a submaximal exercise test (not medically supervised). Please complete the sections below and return this form to you patient of fax to our office by _____.

Thank you.

The American College of Sports Medicine recommends a graded exercise test prior to engaging in an exercise program for the following reasons:

- People with two or more cardiac risk factors.
- People exhibiting signs or symptoms suggestive of cardio pulmonary or metabolic diseases.
- People with documented heart diseases.

Please mark one of the following boxes:

- ☐ Patient Cleared to exercise without restrictions.
- ☐ Patient cleared to exercise with the following restrictions.
- ☐ Patient NOT cleared to exercise due to:

I have ☐ have not ☐ provided a current blood lipid and glucose profile.

Patient diagnosis (if any): _____

Medications that may affect participation: _____

Comments: _____

Send periodic progress report: Yes ☐ No ☐

Physician Signature:_____ Date: _____

Physician Name:_____

Address:_____

City:_____ State:_____ Zip:_____ Phone: ( )_____

E-Mail: _____

BodyEvolver

_____ plans to engage in a scientifically based health, fitness and nutrition program designed to support optimal health. An aerobic exercise and resistance training program will be designed based on a submaximal exercise test (not medically supervised).

Please complete the sections below and return this form to your patient or fax to our office by _____.

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The American College of Sports Medicine recommends a graded exercise test prior to engaging in an exercise program for the following reasons:

- People with two or more cardiac risk factors.
- People exhibiting signs or symptoms suggestive of cardio pulmonary or metabolic diseases.
- People with documented heart diseases.

Self-Reported or diagnosed cardiovascular disease, diabetes or risk factors. A graded exercise test (GXT) is requested (mark one of the following):

☐ Results of current GXT (12 months or less) enclosed with recommendations.
☐ I recommend patient undergo a Graded Exercise Test (GXT).
☐ Patient clear to exercise with the following guidelines

- Training heart rate: _____ BPM. Blood Pressure NOT to exceed _____/_____ mmHg.
- Frequency _____times/week for _____minutes of (continuous/discontinuous exercise.
- Strength training: Yes/No Limits:_____
- Other:_____

☐ Patient cleared to exercise with the following restrictions.
☐ Patient NOT cleared to exercise due to.

I have ☐ have not ☐ provided a current blood lipid and glucose profile.

Patient diagnosis (if any): _____
Medications that may affect participation: _____
Comments: _____

Send periodic progress report: Yes ☐ No ☐

Physician Signature:_____ Date: _____
Physician Name:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone: ( )_____
E-Mail: _____