

**Exercise History and Attitude Questionnaire
Personal Training Program**

Clients Name: _____ **Date:** _____

1. In the past six months, how often have you engaged in physical activity?

- Regularly (3 to 4 times/week)
- Semi-regular (1 to 2 times/week)
- Sporadic (1 to 2 times/month)
- None

2. Do you have any negative feelings toward, or have you had any bad experiences with, physical activity programs. *Please circle yes or no.*

Yes / No If yes, please explain _____

3. Circle the number that corresponds to the response which best describes you for each of the following statements (1= low ability/interest, 5 = high ability/interest).

Importance of completion during exercise.

1 2 3 4 5

How hard do you like to be pushed or motivated during exercise?

1 2 3 4 5

Present cardiorespiratory (aerobic) fitness.

1 2 3 4 5

Present muscular fitness.

1 2 3 4 5

Present flexibility.

1 2 3 4 5

4. Do you start exercise programs but then find yourself unable to stick with them?

Yes No

5. Are you currently involved in regular aerobic exercise?

Yes / No If yes, specify the type of exercise(s) _____

Minutes per day _____ Days per week _____

If no, why did you stop or why do you not exercise currently?

6. Rate your perception of the exertion of your exercise program (circle the number):

(1) Light (2) Fairly light (3) Somewhat hard (4) Hard

7. What other exercise, sport or physical activities have you participated in the last six months? _____

Minutes per day _____ Days per week _____

8. What types of physical activity do you consider "fun"?

9. What do you want exercise to do for you?

10. Specifically describe what you would like to accomplish through this fitness program during the next:

- 1-month _____
- 4 months _____
- 1-year _____

11. How much time are you willing to devote to an exercise program?

Minutes per day _____ Days per week _____

12. Have you ever-experienced soreness after a workout?

Yes /No If yes, circle the number that best applies to the experience:

(1) Pleasurable (2) Tolerable (3) Never want to experience it again!

Nutrition

13. How many meals and/or snacks do you have per day?

14. Do you feel you eat healthy most of the time?

Yes or No. If no, why not? _____

15. How many glasses of water do you drink per day? Tick circle

0-2

3-5

6-8

9-12

more than 12

Fitness Goals

1.

2.

3.

Training Availability

Please mark the days you are available to train & write in the times for each day.

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____