



# Custom Strength

## Client "About Me" Sheet

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ in. WEIGHT: \_\_\_\_\_ lbs. AGE: \_\_\_\_\_

PHYSICIANS NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

### PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

	Questions	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you perform physical activity?		
3	In the past month, have you had chest pain when you were not performing any physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?		
7	Do you know of any other reason why you should not engage in physical activity?		

*If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.*

### GENERAL & MEDICAL QUESTIONNAIRE

	Occupational Questions	Yes	No
1	What is your current occupation?		
2	Does your occupation require extended periods of sitting?		
3	Does your occupation require extended periods of repetitive movements? (If yes, please explain.)		



<b>Occupational Questions</b>		<b>Yes</b>	<b>No</b>
<b>4</b>	Does your occupation require you to wear shoes with a heel (dress shoes)?		
<b>5</b>	Does your occupation cause you anxiety (mental stress)?		
<b>Medical Questions</b>		<b>Yes</b>	<b>No</b>
<b>1</b>	Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.)		
<b>2</b>	Have you ever had any surgeries? (If yes, please explain.)		
<b>3</b>	Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? (If yes, please explain.)		
<b>4</b>	Are you currently taking any medication? (If yes, please list.)		
<b>Recreational Questions</b>		<b>Yes</b>	<b>No</b>
<b>1</b>	Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.)		
<b>2</b>	Do you have any hobbies (reading, gardening, working on cars, exploring the Internet, etc.)? (If yes, please explain.)		
<b>Workout Questions</b>			
<b>1</b>	How much time do you feel you will commit to working out? (times per week; duration each time)		
<b>2</b>	What are your goals for working out?		

Occupational Questions		Yes	No
<b>3</b>	Where will you be working out? (home or gym)		
<b>4</b>	Please check off the equipment that you have access to from the list below, and add any that you have access to that are not listed (note – if you have very few of these below, please do not be alarmed! We can create a custom program for everyone, with minimal equipment.):		
<b>a</b>	Y/N	Dumbbells	Weight range:
<b>b</b>	Y/N	Barbell and weight plates	Weight range:
<b>c</b>	Y/N	Squat cage/rack	
<b>d</b>	Y/N	Bench (for bench press)	
<b>e</b>	Y/N	Sturdy coffee table or other furniture that you could use for some exercises (e.g. place one hand and knee on the table with one foot on floor and other arm holding a weight)	
<b>f</b>	Y/N	Stability ball (swiss ball; exercise ball)	
<b>g</b>	Y/N	Bands (e.g. theraband, or bands with handles. Please describe including resistance if known)	
<b>h</b>	Y/N	Plyometric boxes	How high?
<b>i</b>	Y/N	Step (i.e. like the type used in aerobics classes)	How high?
<b>j</b>	Y/N	Cardio equipment (elliptical, treadmill, stationary bike – not Recumbent, or running, biking outside). Please describe	
<b>K</b>	Y/N	Do you have access to space for agility work? It does not have to be big. Please describe	
<b>l</b>	Y/N	Do you run? Can you run? If not, why not?	
<b>m</b>	Y/N	Bosu ball?	



Occupational Questions			Yes	No
<b>n</b>	Y/N	Cones and/or hurdles/mini-hurdles and/or agility ladder. Please describe.		
<b>o</b>	Y/N	Medicine balls?		
<b>p</b>	Y/N	TRX or other suspension trainer device?		
<b>5</b>	Do you currently workout? (If so, please briefly describe what you do)			
<b>6</b>	Are there any exercises that you have done in the past that caused you pain? (If so, please describe, including what exercises, how long ago, and when you felt the pain)			
<b>7</b>	Additional comments?			