active kinetix
fitness & rehabilitation

BCAK Association of Kinesiologists

# New Client Form

Name: ______________________________________________

Address: ______________________________________________
Number Street City Postal Code

Phone Number (s): H: ________________ C: ______________________

Email Address: ______________________________________________

Date of Birth: ____/____/_______ Occupation: ______________________

Mon/ Day/ Year

Referred By: ____________________ Training Facility: ______________________

Emergency Contact: ______________________________________________
Name/Relation Phone

Physician: ______________________________________________
Name Phone

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## Lifestyle Questions for Success

1. How many hours of sleep do you get a night? _________
2. On a scale of 1-10 (1=very low; 10=very high), your stress level is: _____
3. Do you smoke at present? Yes/No ______ Have you ever smoked? _____
4. Do you drink alcohol? Yes/No ______ If yes, how many drinks/week?__________
5. Nutrition: For nutritional consultation, please fill out the Diet/Nutrition History at the end of this form
6. Have you been involved in an exercise program in the past? Explain _______________
7. Do you have any injuries (past and present):

   ______________________________________________
8. Have you had any Motor Vehicle Accidents? If yes, when? Any injuries:?

   ______________________________________________
9. When are you available to attend sessions?
   Days/Times:______________________________________________

10. Are you able to provide at least 24 hour notice if there needs to be changes to the scheduled session. Yes___ No___
(Short notice cancellations will be billed) Initial: __________ __________________
*Date*

**PAR-Q:** **(Physical Activity Readiness Questionnaire)**

(A Questionnaire for People Aged 15 to 69)

The following 7 questions are designed to determine your medical risk in beginning an exercise program. **If you answered YES to one or more questions:**
Talk with your doctor by phone or in person BEFORE you start becoming much more physically active. Tell your doctor about the PAR-Q and which questions you answered YES.

**Yes** **No**

1. Has your doctor ever said you have a heart condition and you should only do physical activity recommended by a doctor?

2. Do you feel pain in your chest when you do physical activity?

3. In the past month, have you had chest pain when you were not doing 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 (for example, back, knee or hip) that could be made worse by a change in your physical activity?

6. Are you currently taking any prescription drugs? If yes, please list:

______________________________________________________________________

______________________________________________________________________

7. Do you know of any other reason why you should not do physical activity?

"I have read, understood and completed this questionnaire and intake form Any questions I had were answered to my full satisfaction."

NAME ______________________________________________

SIGNATURE ______________________________________________

DATE ______________________________________________

WITNESS ______________________________________________

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Email: info@activekinetix.com
Phone: 604.999.1853
www.activekinetix.com

## Exercise

1. **Fitness goals:** *Check all that apply*

◊ Lose Body Fat
◊ Develop Muscle
◊ Injury Rehabilitation
◊ Improve Medical Health *(heart disease, diabetes, etc)*
◊ Stress Management
◊ Design Beginner Fitness Program
◊ Design Advanced Fitness Program
◊ Nutritional Education
◊ Train for a Specific Sport
◊ Motivation
◊ Pre/Post Natal
◊ Other ______________________

2. On a scale of 1—10 (1=lowest; 10=highest) how would you rate your fitness level: _____
3. Do you currently participate in some form of Exercise?:
☐ 5-7 times/week ☐ 3-4 times/week ☐ 1-2 times/week ☐ not in the past 6 months

If active, list your activities: (Cardio, Weights, Sports, Yoga, etc):

| Activity | # of Days/Week | Duration | Intensity (low, med, high) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

4. What is your primary reason for starting an exercise program?
____________________________________________________________________________

5. When would you ideally like to achieve your by?
____________________________________________________________________________

## Nutrition/Diet

1. What do you consider a good weight for yourself ? ____________________
2. Do you eat breakfast? If yes. What? ______________________________________
3. # of meals you eat per day: ______ . # of meals you eat at home: per day ______
4. Do you drink pop/juice/coffee/tea? How much?
   ______________________________________________________________________
5. Do you take vitamins? If yes, list:
   ______________________________________________________________________
6. What kind of snacks do you choose?
   ______________________________________________________________________
7. Do you read food labels?
   ______________________________________________________________________
8. What do you think you need to work on the most as far as nutrition is concerned?
   ______________________________________________________________________