



L'Équipe
trainwithmike™

Evaluation Information Sheet

General Info

Date:

Name:

Date of Birth:

Address:

Telephone:

Email Address:

Health Care Provider information:

Height:

Weight

AVAILABILITIES

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

Sunday

GOALS

Number in order of importance – 1 being the most important

Weight Loss

Improve Flexibility

Improve Posture

Gain Muscle

Sports specific conditioning

Decrease Stress

Improve Strength

Try something New

Rehabilitation

Improve Cardio Fitness

Improve Diet

Other

How would you know when you are successful and your goals have been reached? What are your measures of success?

- Measured Weight Loss
- Body Fat %
- Strength Gain
- Clothes fitting better
- More Energy
- Improved Mobility
- Inches Lost
- Increased endurance
- Other _____

TRAINING INFO

Why are you coming to see a trainer?

Have you ever had a health/fitness program designed for you by a professional trainer before? If so, how long ago?

If Yes, what did you like best about the experience?

What did you like least?

On a scale of 1-10, how would you rate your present fitness level (1-worst)

Are you participating in any physical activity now? What & how often?

If not, how long has it been since you've been involved in a regular exercise program?

Health and Lifestyle

Medical Information

Please tick if any of these relate to you and provide details:

- Do you suffer from back pain?
- Do you experience frequent headaches?
- Are you pregnant?
- Do you have high blood pressure?
- Do you have high cholesterol?
- Are you epileptic?
- Have you ever had surgery?
- Have you ever broken any bones?
- Do you experience stiff, swollen or painful joints?
- Do you have difficulty sleeping?
- Do you experience fatigue or lack of energy?
- Have you ever been advised by a physician to avoid any type of exercise?
- Do you (or someone in your family) have a cardiac condition?
- Do you have any allergies?
- Have you ever seen a Nutritionist/Registered Dietician?

- Do you smoke?
- Have you smoked in the past?
- Do you live with a smoker?
- Do you suffer from Asthma
- Do you suffer from a Hernia
- Other _____

If you have checked yes to any of the above, please explain some of the details.

What, if any, health condition, do you have that limits you the most?

Do specific activities or positions alleviate your symptoms?

When is the pain worse?

On a scale of 1 to 10 (1=no stress, 10=a lot of stress), please rate the amount of stress in your career.

On a scale of 1 to 10 (1=no stress, 10=a lot of stress), please rate the amount of stress in your personal life.

What is the heaviest you ever weighed, and how old were you at that time?

Are you taking any medications?

How many hours do you spend in front of a computer?

How many days do you have to commit towards working out?

DIET

What have you eaten today?

Do you drink alcohol - if yes how much per week

Do you drink Coffee - how much per day?

How often do you indulge per week?

Are you now, or have you ever been on a diet?

How many meals do you eat per day?

Which is the largest meal of the day?

How often do you snack per day/ what do your snacks consist of?

Do you usually eat breakfast?

Do you consider your nutrition habits to be good, fair or poor?

What is your guilty pleasure?

How much water do you consume daily?

Terms:

- All training packages expire one year after the first performed session of the package, except for starter packages, which must be performed within one month of the evaluation.
- Single 60 min sessions are available for \$55-\$60/session after initial starter package (not including gym access pass for non-members).
- All sessions and packages must be paid in full and in advance.
- **All cancellations must be made 24 hours before each scheduled session. You will automatically be charged the full amount for any late cancellations.**
- I have read and understood the cancellation policy and payment terms.

I have answered all the questions on this evaluation accurately.

Name:

Date:

Signature:

TRAINERS NOTES

Postural Analysis:

1. Anterior View:
2. Right Side View:
3. Left Side View:
4. Posterior View:

Range of Motion Tests

Left

1. Hamstring:
2. Clavicular portion of Pec Major:
3. Sternal portion of pec major:
4. Supine Front shoulder:
5. Lat :
6. External shoulder rotators:
7. Internal shoulder rotators
8. Pec Minor:
9. Apley Test:
10. External hip rotators
11. Inferior Trapezius:
12. Thomas Test:

Right

Movement Screens

1. Arms Overhead Deep Squat:
2. In Line Lunge:
3. Hurdle step/Step Ups:
4. 1 leg Anterior/side Reaches:

Body Fat and Weight

Endurance/Strength/Power Tests

- 1) Push-up Test : modality -
- 2) Pull-up Test : modality -
- 3) Lunge Test : modality -
- 4) Plank Test :
- 5) Vertical Jump Test :
- 6) Step up Test :

7) Walk /or/ Run Treadmill Test :