

NEW CLIENT INVENTORY



Date: _____

First Name: _____ Last Name: _____

Address : _____ City: _____

State: _____ Zip: _____ Email: _____

Phone {home}: _____ Phone {cell}: _____

Preferred way to contact you? Email / Cell / Home Best time to reach you? _____

PERSONAL INFORMATION

Age/DOB: _____ Gender: M F Height: _____ Weight _____

Marital Status: Single Married Divorced Widowed

Children: Yes / No Occupation: _____

Current Stress Level: 0 1 2 3 4 5 6 7 8 9 10

Hours/week at work: _____ Do You Travel for Work: Y N

How did you hear about Zeren PT & Performance? _____

HEALTH HISTORY

Have you or anyone in your family had coronary artery disease? Y N

Do you often feel faint or have spells of severe dizziness? Y N

Do you ever have chest, shoulder, neck, or arm pains after exercise? Y N

Have you ever fainted, felt dizzy, or unusually winded after exercise? Y N

Are you diabetic, have a thyroid condition, or any chronic condition? Y N

Explain: _____

Are you using any medications? Y N

List: _____

Is your cholesterol level high? Y N Cholesterol Count: _____

Have you ever had a complete physical exam including stress test on a treadmill or ergometer? Y N

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Do you have any condition that a doctor says may limit your exercise? Y N

Have you ever smoked? Y N If yes, when did you quit? _____

Have you ever had a joint or back disorder or any current injury? Y N

Please explain: _____

Please list any injuries/surgeries that you've had in the past 3 years.

ATHLETIC HISTORY

List your past sports and years of participation

Do you currently have a strength and conditioning program or do you cross train in the "off" season? (describe)

Are you familiar with free weight exercises? Y N

CURRENT ATHLETICS

Primary Sport: _____

Have you planned what races you will compete in for next season? If so, please list with dates and in priority:

- | | |
|----------|-------------|
| A. _____ | Date: _____ |
| B. _____ | Date: _____ |
| C. _____ | Date: _____ |
| D. _____ | Date: _____ |
| E. _____ | Date: _____ |

Describe your three most important goals? (in order of importance)

1. _____

2. _____

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3. _____

What is your training week like now (Type, duration, intensity)?

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Sunday: _____

Is the training schedule listed above high, normal, or low for you?

What is your longest workout in the last 3 weeks? 1hr 2hr 3hr 4hr 5+hrs

In reality, how many weekly hours do you have available to train?

0-2 2-4 4-6 6-8 8-10 10-12 12-14 14-16 16-18 20+

Which day(s) is best for you to take off from training? M T W Th F Sat Sun

What time of day do you expect to do most of your training during the work week? _____

Do you have a stationary trainer? Y N Rollers? Y N

Do you ever train with a group? Y N

Do you own a heart rate monitor? Y N Are you familiar with HR training? Y N

Do you train with a power meter?: Y N

What is the highest HR you've observed during exercise in the last year? _____

Do you know your current lactate threshold heart rate/wattage?: _____

Please list and describe how it was determined: _____

Signature: _____

Date: _____

First Name: _____ Last Name: _____