Date:
Time:
Trainer:

CGC WELLNESS QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will be filed with your PAR-Q+

Name: please print	**DOB:**

Health Care Professionals and Lifestyle:

Do you receive any regular treatment from the following?

☐ Doctor
☐ Massage Therapist
☐ Physiotherapist
☐ Chiropractor
☐ Dietitian
☐ Other__________________

What is your current occupation?____

How much sleep do you get in an average night? ☐ <4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ >9

Injuries and Conditions

Do you currently have any injuries? If yes, please elaborate:

____

____

Do you have any other chronic conditions or past injuries not mentioned in your PAR-Q+? If yes, please elaborate:

____

____

Do you use any orthotic devices (ex: braces, foot orthotics, wraps, etc.)?

____

Past and Current Activity Levels

Do you have previous experience with resistance/weight training or other fitness training? If yes, please elaborate:

____

____

How often do you currently work out per week? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐>7

What exercise(s)/workout(s) are you currently doing?

____

____

____

What exercises do you enjoy?

☐ walking
☐ jogging/running
☐ swimming
☐ cycling/spin
☐ tennis/squash/badminton
☐ skating/hockey
☐ field sports (soccer, disc golf, etc.)
☐ court sports (basketball, volleyball, etc.)
☐ weight/resistance training
☐ Crossfit
☐ bootcamps
☐ yoga/Pilates
☐ group fitness classes
☐ Other_________________________
☐ Other_________________________

Main Goals:	Trainer Notes:
☐ Increase cardiovascular endurance ☐ Increase muscle strength ☐ Increase muscle mass ☐ Increase flexibility ☐ Weight loss ☐ Lower cholesterol ☐ Lower blood pressure ☐ Manage other chronic conditions ☐ General fitness ☐ Other___________________________	
Workout Frequency:	**Trainer Notes:**
☐ 1X weekly ☐ 2X weekly ☐ 3X weekly ☐ 4X weekly ☐ 5X weekly ☐ 6X weekly ☐ 7X weekly ☐ more than 1X daily ☐ Other________________________________	
Workout Time:	**Trainer Notes:**
☐ 30 min per visit ☐ 45 min per visit ☐ 1 hr per visit ☐ 1.5 hrs per visit ☐ 2 hrs per visit ☐ >2 hrs per visit ☐ Other_______________________________	

Anything else you would like to tell us?:

Signature:	Date: