MARKITO
FITNESS & NUTRITION

HELPING PEOPLE LEAD HEALTHIER LIVES

CLIENT PROFILE

Please complete and return at least 2 days prior to your first scheduled session.

All information received on this form will be treated as strictly confidential. Please fill out the forms ***completely and accurately***. This information is essential to helping us develop a safe and effective program that addresses your needs, goals and interests.

Date (M/D/YYYY): _____

Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Address : _____ _____ _____
Street City Postal/zip Code

Phone: (home) _____ (mobile) _____

Email address: _____

Occupation: _____

Referred by: _____

Interested in: ◯ Personal Training ◯ Nutrition/Health Consultations

Emergency Contact: _____ Relationship: _____ Phone: _____

Physician's Name: _____ Physician's Phone: _____

Please provide 48 hours notice if you need to cancel or reschedule your appointment.

Tel: 514.735.1223
Email: contact@markitonutrition.com

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. **Please mark YES or NO to the following:**

1. Has a doctor ever told you that you have heart trouble? **YES** ☐ **NO** ☐
2. Do you frequently have pains in your chest when you perform physical activity? **YES** ☐ **NO** ☐
3. In the past month, have you had chest pain when you were not doing physical activity? **YES** ☐ **NO** ☐
4. Do you lose your balance because of dizziness or do you ever lose consciousness? **YES** ☐ **NO** ☐
5. Do you have high blood pressure? **YES** ☐ **NO** ☐
6. Do you have a bone or joint problem such as arthritis that could be made worse by a change in your physical activity? **YES** ☐ **NO** ☐
7. Have you had a recent surgery? **YES** ☐ **NO** ☐
8. Do you know of any other reason why you should not do physical activity? **YES** ☐ **NO** ☐
9. Are you over the age of 65 and not accustomed to vigorous exercise? **YES** ☐ **NO** ☐

If you have marked YES to any of the above, please elaborate below:

Do you take any medications, either prescription or non-prescription, on a regular basis? **YES** ☐ **NO** ☐

List your medication(s), and purpose for taking:

How does this medication affect your ability to exercise or achieve your fitness goals?

More Medical Information

When did you last have a complete physical examination?

Do you suffer from any cardiovascular illness?

Do you suffer from asthma? **YES** ☐ **NO** ☐

Do you have chronic back or neck pain **YES** ☐ **NO** ☐ If yes, please elaborate:

Do you suffer from osteoporosis? **YES** ☐ **NO** ☐

Have you ever had any surgery or accidents that would pertain to restriction of exercise? **YES** ☐ **NO** ☐
If yes, please elaborate:

Do you have any food allergies or sensitivities? **YES** ☐ **NO** ☐ If yes, please elaborate:

Have you taken antibiotics over the past 5 years? **YES** ☐ **NO** ☐

How often do you have a bowel movement?

Do you have to strain to have a bowel movement?: ◯ Yes ◯ No ◯ Occasionally

Related to particular food or circumstances?

Is there undigested food in your stools?: ◯ Yes ◯ No ◯ Occasionally

Have you ever experienced fungal infections (e.g. jock itch, athlete's foot)? **YES** ☐ **NO** ☐

If yes, please describe:

Have you had kidney or gallstones? **YES** ☐ **NO** ☐ If yes, please elaborate:

WOMEN

Have you noticed any changes in menses, for example the frequency, duration, flow, clotting, or other changes? **YES** ☐ **NO** ☐ If so, please specify:

Do you suffer from PMS symptoms? **YES** ☐ **NO** ☐ If so, please specify:

Do you take birth control pills? **YES** ☐ **NO** ☐

Are you pre or post-menopausal, and are you experiencing any menopausal symptoms? **YES** ☐ **NO** ☐
Please specify:

MEN

Have you experienced any prostate problems (e.g. frequent urination, discomfort during urination)? **YES** ☐ **NO** ☐ If yes, please elaborate:

HEALTH READINESS QUESTIONNAIRE

Have you ever had any of the following?

1. Heart attack or heart failure? **YES** ☐ **NO** ☐
2. Heart Surgery? **YES** ☐ **NO** ☐
3. Metabolic Diseases? **YES** ☐ **NO** ☐
4. A pacemaker or other heart device? **YES** ☐ **NO** ☐
5. A heart valve or congenital heart disease? **YES** ☐ **NO** ☐
6. Pulmonary disease? **YES** ☐ **NO** ☐
7. A Stroke? **YES** ☐ **NO** ☐
8. Coronary Artery Disease (CAD)? **YES** ☐ **NO** ☐
9. If you are a woman, are you pregnant now or have given birth within the last 6 months? **YES** ☐ **NO** ☐
10. Musculoskeletal or nerve problems? **YES** ☐ **NO** ☐

Have you ever experienced any of the following?

1. Pain in your chest, neck or jaw? **YES** ☐ **NO** ☐
2. Shortness of breath with mild exertion? **YES** ☐ **NO** ☐
3. Palpitations, tachycardia, or irregular heart beat? **YES** ☐ **NO** ☐
4. Orthopnea or Paroxsomal Nocturnal Dyspnea? **YES** ☐ **NO** ☐
5. Intermittent claudication or thrombosis? **YES** ☐ **NO** ☐
6. Ankle swelling? **YES** ☐ **NO** ☐
7. Heart murmur? **YES** ☐ **NO** ☐
8. Dizziness? **YES** ☐ **NO** ☐

Indicate if you have had any of the following or if any apply to you:

1. You are a male older than 45 years of age. **YES** ☐ **NO** ☐
2. You are woman over 55 years of age or have had a hysterectomy or are postmenopausal. **YES** ☐ **NO** ☐
3. You smoke or have quit smoking in the last 6 months. **YES** ☐ **NO** ☐
4. You have blood pressure greater than 140/90. **YES** ☐ **NO** ☐

   If you know your blood pressure enter it here:
5. You are physically inactive (i.e. get less than 30 minutes of physical activity at least 3 days/week) **YES** ☐ **NO** ☐
6. You have total cholesterol greater than 150 mg/dL. **YES** ☐ **NO** ☐

   If you know your cholesterol enter it here:
7. You have a close male blood relative that had a heart attack before age 55 or a close female relative that had a heart attack before age 65. **YES** ☐ **NO** ☐
8. You have diabetes or take medication to control blood sugar. **YES** ☐ **NO** ☐
9. Take prescription medication. **YES** ☐ **NO** ☐
10. You are more than 20 pounds overweight. **YES** ☐ **NO** ☐

You certify that the answers to the questions outlined on the PAR-Q and Health Readiness Questionnaire are true and complete to the best of your knowledge. You acknowledge that medical clearance is required if you have answered "Yes" to any of the questions on these forms. You understand and agree that it is your responsibility to inform your Personal Trainer of any conditions or changes in your health, now and on going, which might affect your ability to exercise safely and with minimal risk of injury.

You have read and understand this term: _____ (initial).

It is your understanding and you have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and in very rare instances heart attack, stroke, or even death. You further understand and have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, you have been told, will be made to minimize these occurrences by proper assessments conducted by Markito Fitness & Nutrition and by your own careful control of exercise efforts. You fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is your desire to participate as herein indicated.

You have read and understand this term: _____ (initial).

Print Name _____ Date (D/M/YYYY): _____

Signature of Parent _____
or Guardian (for participants under the age of 18)

LIFESTLE RELATED QUESTIONS

1. Do you smoke? **YES** ☐ **NO** ☐ If yes, how many?
2. Do you drink alcohol? **YES** ☐ **NO** ☐ If yes, how many glasses per week?
3. Do you drink coffee? **YES** ☐ **NO** ☐ If yes, how many cups per day?
4. Do you feel sleep deprived? **YES** ☐ **NO** ☐ How many hours do you regularly sleep at night?
5. Describe your job: ◯ Sedentary ◯ Active ◯ Physically Demanding
6. Does your job require travel? **YES** ☐ **NO** ☐
7. On a scale of 1-10, how would you rate your stress level (1=very low 10=very high)?
8. List your 3 biggest sources of stress:

   a. b. c.
9. Is anyone in your family overweight? ◯ Mother ◯ Father ◯ Sibling ◯ Grandparent
10. Were you overweight as a child? **YES** ☐ **NO** ☐ If yes, at what age(s)?

FITNESS HISTORY

1. When were you in the best shape of your life?
2. Have you been exercising consistently for the past 3 months? **YES** ☐ **NO** ☐
3. When did you first start thinking about getting in shape?
4. What if anything stopped you in the past?
5. On a scale of 1-10, how would you rate your present fitness level (1=Worst 10=Best)?

NUTRITION RELATED QUESTIONS

1. On a scale of 1-10, how would you rate your Nutrition (1=very poor 10=excellent)?
2. How many times a day do you usually eat (including snacks)?
3. Do you skip meals? **YES** ☐ **NO** ☐
4. Do you eat breakfast? **YES** ☐ **NO** ☐
5. What activities do you engage in while eating? (TV, reading etc)
6. How many glasses of water do you consume daily?
7. Do you feel drops in your energy levels throughout the day? **YES** ☐ **NO** ☐ If yes, when?
8. Do you know how many calories you eat per day? **YES** ☐ **NO** ☐ If yes, how many?

9. Are you currently or have you ever taken a multivitamin or any other food supplement? YES ☐ NO ☐

If yes, please list the supplements:

10. At work or school, do you usually: ◯ Eat out ◯ Bring food

11. How many times per week do you eat out?

12. Do you do your own grocery shopping? YES ☐ NO ☐

13. Please name about 5 items that have a food label and are currently in your fridge, freezer, or pantry.

14. Do you do your own cooking? YES ☐ NO ☐

15. Besides hunger, for what other reason(s) do you eat?
☐ Boredom ☐ Social ☐ Stressed ☐ Tired ☐ Depressed ☐ Happy ☐ Nervous

16. Do you eat past the point of fullness? ◯ Often ◯ Sometimes ◯ Never

17. Do you eat foods high in fat and sugar? ◯ Often ◯ Sometimes ◯ Never

18. Do you consume processed food? ◯ Often ◯ Sometimes ◯ Never

19. Are you aware of the benefits of a whole foods plant-based diet? YES ☐ NO ☐

20. List 3 areas of your Nutrition you would like to improve:

a. b. c.

EXERCISE RELATED QUESTIONS

(Skip to next section if you are presently inactive).

1. How often do you take part in physical exercise?

◯ 5-7x/week ◯ 3-4x/week ◯ 1-2x/week

2. If your participation is lower than you would like it to be, what are the reasons?

◯ Lack of Interest Illness/Injury ◯ Lack of Time ◯ Other

3. How long have you been consistently physically active for?

4. What activities are you presently involved in?

Cardio/Sports/Stretching	Frequency/Week	Average Length	Easy/Mod/Hard

Strength Training	Frequency/Week	Average Length	Easy/Mod/Hard

List exercises:

5. Please circle all the activities that interest you:

☐ Aerobic Fitness Classes	☐ Indoor Cycling	☐ Snowshoeing
☐ Baseball	☐ Kayaking	☐ Soccer
☐ Basketball	☐ Partner Training	☐ Swimming
☐ Boxing/Martial Arts	☐ Ping Pong	☐ Tennis
☐ Cross Country Skiing	☐ Private Personal Training	☐ Triathlon
☐ Football	☐ Racquetball	☐ Volleyball
☐ Golf	☐ Rock climbing	☐ Walking
☐ Group Personal Training	☐ Running	☐ Water Sports
☐ Hiking	☐ Skiing	☐ Weight Lifting
☐ Ice Skating	☐ Snowboarding	☐ Yoga

DEVELOPING YOUR FITNESS PROGRAM

1. Please circle how you prefer to exercise:

a) ◯ INSIDE ◯ OUTSIDE ◯ COMBINATION

b) ◯ LARGE GROUPS ◯ SMALL GROUPS ◯ ALONE ◯ COMBINATION

c) ◯ MORNING ◯ AFTERNOON ◯ EVENING

2. Where do you prefer to exercise? ◯ At home ◯ At work ◯ At the gym

Why?

3. Realistically, how often a week would you like to exercise? x/week

4. Realistically, how much time would you like to spend during each exercise session?

5. What are the best days during the week for you to commit to your exercise program?

M☐ T☐ W☐ T☐ F☐ S☐ S☐

6. If you could design your own exercise program what would an ideal training week look like to you? Please be specific. List your favorite activities, rest days, time spent etc.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

GOAL SETTING

How can your Personal Trainer/Nutritionist help you? Please check that which applies.

☐ Lose Body Fat ☐ Improve body shape ☐ Develop Muscle Tone ☐ Improve posture ☐ Reverse disease
☐ Rehabilitate an Injury ☐ Increase energy ☐ Nutrition Education ☐ Start an Exercise Program
☐ Design a more advanced program ☐ Safety ☐ Sports Specific Training ☐ Increase Muscle Size ☐ Fun
☐ Motivation

Other:

In order to increase your chances of being successful at achieving your goals, a certain protocol should be followed. Please ensure all your goals are 'SMART'.

S= Specific (Provide details, how long, how much etc.)
M= Measurable (How will you measure whether you've reached your goals)
A= Attainable (Be realistic, set smaller goals)
R = Rewards-Based (Attach a reward to each goal)
T = Time Frame (Set specific dates for goals)

1. Please list in order of priority, the fitness goals you would like to achieve in the next 3-12 months?
   a)
   b)
   c)

2. How will you feel once you've achieved these goals? Be specific.

3. Where do you rate health in your life? ◯ Low priority ◯ Medium Priority ◯ High priority
4. How committed are you to achieving your fitness goals? ◯ Very ◯ Semi ◯ Not very
5. What do you think the most important thing your Exercise & Nutrition Specialist can do to help you achieve your fitness goals?

6. Outline what you feel are the obstacles or your potential actions, behaviors or activities that could impede your progress towards accomplishing your goals (i.e. not training consistently, upcoming vacation, busy season at work, not following the program, allowing other responsibilities to become a priority over your health, etc.).

7. Outline 3 methods that you plan to use to overcome these obstacles:

   a. b. c.

You've reached the end of your client form! Is there anything you would like to add?

SUBMIT