YOUR PERSONAL TRAINING PACKAGE QUESTIONNAIRE

Congratulations on making the life-changing decision to allow our team at Greenfield Fitness Systems to guide you to optimum health, wellness, nutrition, fat-burning and lean muscle toning.

We will be **completely customizing** your entire program, but we must first have critical metabolism, health and lifestyle information. **Please contact us if you have any questions.**

When you complete this form, you may do any of the following:

A) print, scan and e-mail to support@greenfieldfitnesssystems.com
B) complete the form online, save and e-mail to support@greenfieldfitnesssystems.com
C) print and mail to Ben Greenfield, 8515 N Argonne Road, Spokane WA 99217

Upon receiving this form, we will contact you within 48 hours with final information about your program. **Now it's time to take the first step…your journey to achieving total success begins on the next page…**

Your Contact Details

Name: _____ Age: _____ Today's Date: _____

Primary e-mail address: _____

Primary phone: _____

Mailing address: _____

Your Lifestyle

1. Describe your job.

2. Do you consider your job physically challenging or active?

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

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

1 2 3 4 5 6 7 8 9 10

5. 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.

1 2 3 4 5 6 7 8 9 10

6. What time do you usually go to bed at night and wake up in the morning?

7. Are there any other notes about your lifestyle that you would like to share?

21 Important Questions About Your Health History

If you answer "yes" to any of these questions, please provide details such as date of occurrence, frequency, intensity, amount, etc.

1. Do you suffer from back pain?

Yes: ____ No: ____ Details: _____

2. Are you sensitive to touch/pressure in any area?

Yes: ____ No: ____ Details: _____

3. Do you have tension, numbness or pain in a specific area?

Yes: ____ No: ____ Details: _____

4. Do you experience frequent headaches?

Yes: ____ No: ____ Details: _____

5. Are you pregnant?

Yes: ____ No: ____ Details: _____

6. Have you ever given birth?

Yes: ____ No: ____ Details: _____

7. Do you have high blood pressure?

Yes: ____ No: ____ Details: _____

8. Do you have high cholesterol?

Yes: ____ No: ____ Details: _____

9. Have you ever had surgery?

Yes: ____ No: ____ Details: _____

10. Have you ever broken any bones?
Yes: ____ No: ____ Details: _____

11. Do you experience stiff, swollen or painful joints?

Yes: ____ No: ____ Details: _____

12. Do you have difficulty sleeping?

Yes: ____ No: ____ Details: _____

13. Do you experience fatigue or lack of energy?

Yes: ____ No: ____ Details: _____

14. Do you experience cold hands or feet?

Yes: ____ No: ____ Details: _____

15. Have you ever been advised by a physician to avoid any type of exercise?

Yes: ____ No: ____ Details: _____

16. Have you ever been knocked unconscious or suffered a concussion?

Yes: ____ No: ____ Details: _____

17. Do you (or does someone in your family) have a cardiac condition?
Yes: ____ No: ____ Details: _____

18. Do you have any known allergies?

Yes: ____ No: ____ Details: _____

19. Are you currently taking any medications (not nutrition supplements)?

Yes: ____ No: ____ Details: _____

20. Do you smoke or have you smoked in the past?

Yes: ____ No: ____ Details: _____

21. Are there any medical issues which have not been discussed on previous questions?

Yes: ____ No: ____ Details: _____

Your Exercise Status

1. Describe your current exercise routine, if any.

2. What is the heaviest you have weighed, and how old were you at that time?

3. What previous fat loss, lean muscle gain, or body improvement treatment(s) have you tried? Please state what and when.

4. Have you ever had any of the following: physical therapy, chiropractic, massage, acupuncture, Feldenkrais, rolfing, Alexander technique, Other? Please elaborate.

5. Have you ever worked with a personal trainer? If so, provide details:

6. How many days do you have to commit towards exercise (include the approximate number of minutes)?

7. Are there any areas of your body that you consider "problem areas"?

Your Nutrition & Metabolism

1. Have you ever had your metabolism tested?

Yes: ____ No: ____ Details: _____

2. Do you count or track calories?

Yes: ____ No: ____ Details: _____

3. Does a high carb snack or meal, with lots of veggies, bread, toast, cereals, rice, fruits, grains or potatoes as the main food source satisfy or stimulate your appetite?

1 2 3 4 5 6 7 8 9 10
satisfies stimulates

4. Do you notice that you gain a lot of weight when you eat red meat, or lose weight? Do you look slimmer in the mirror or do your clothes fit easier?

1 2 3 4 5 6 7 8 9 10
gain weight lose weight

5. Do you constantly look forward to the next meal, frequently thinking about foods and what you want to eat?

1 2 3 4 5 6 7 8 9 10
yes no

6. What is your appetite like at:

Breakfast?
1 2 3 4 5 6 7 8 9 10
weaker stronger

Lunch?
1 2 3 4 5 6 7 8 9 10
weaker stronger

Dinner?
1 2 3 4 5 6 7 8 9 10
weaker stronger

7. Do higher fat foods and/or higher protein foods such as dark meats, avocados, cream, butter, or coconuts within 1-2 hours of bedtime help you sleep better?

1 2 3 4 5 6 7 8 9 10
yes no

8. If you ate a large salad with some low-fat meat like chicken breast for lunch (versus a higher fat meat like a hamburger patty), how would it affect your productivity the rest of the afternoon? What about if you ate a steak?

Salad:

1 2 3 4 5 6 7 8 9 10

Energetic & satisfied Tired & hungry

Steak:

1 2 3 4 5 6 7 8 9 10

Energetic & satisfied Tired & hungry

9. How often do you typically feel the need to eat on an average day? One meal would be a 1, three meals a day would be a 5, while six to seven meals a day would be a 10.

1 2 3 4 5 6 7 8 9 10

1-2x including snacks 6-7x including snacks

10. How much do you enjoy sour foods like pickles, sauerkraut, or vinegar?

1 2 3 4 5 6 7 8 9 10

love them can't stand them

11. At Thanksgiving or a meal where you eat turkey, assuming all the turkey is moist, if you prefer white meat give yourself a 1, dark meat a 10, and no preference a 5.

1 2 3 4 5 6 7 8 9 10

white meat dark meat

12. What is a typical breakfast?

13. Lunch?

14. Dinner?

15. Describe your snacking habits in between breakfast, lunch, and dinner:

16. Describe your pre-workout nutritional habits, if any:

17. Describe your "during the workout" nutritional habits, if any:

18. Describe your post-workout or nutritional habits, if any:

19. Describe all nutritional supplements you are currently using. Include multi-vitamins, sport supplements, electrolytes, and any special juices, pills, capsules or tablets:

20. How much water do you drink per day, apart from exercise?

21. How much water do you drink during exercise?

22. Please describe any known food sensitivities, or intense likes/dislikes:

23. Do you ever have heartburn, gastrointestinal distress, or stomach problems?

24. Please describe any religious, ethical, or logistical limitations regarding nutrition (include information about any current nutritional sponsors):

25. Use the following section to include any additional nutritional notes:

Your Final Thoughts

Describe what you truly desire from completing this program. **What do you truly desire? Out of your fitness? Out of life? What do you want your body to look like in 1 year? 5 years? In other words, why are you sitting here, taking valuable minutes out of your life to complete this form? What are your specific goals or objectives?** Be as honest and specific as possible, describing your dream body, lifestyle, or health. Pour yourself onto the page. Include anything that you feel would be helpful that you haven't yet had a chance to express. All your responses remain completely confidential!

Thanks for taking the time. We can now use this information to help you reach your dreams. **Yours in health.**

GREENFIELD FITNESS SYSTEMS