Physical Assessment

1. How many days per week do you train?
2. Do you do any type of cardiovascular exercise?
3. Do you have any injuries? (**Please list the past 15 years and any major surgery**)
4. Have you ever had any bone breaks, sprains, fractures, or tears of any kind?
5. Have you done physical therapy for any diagnosed issues?
6. Do you have any diseases or illnesses of any kind (physical or mental)?
7. Have you or are you taking any medications?
8. Do you have any physical ailments that would inhibit you from reaching your physical goals?
9. Do you have any cancer or going through chemotherapy?
10. Are you pregnant?
11. Do you have epilepsy?
12. Do you have a pacemaker?
13. Do you have any family history of illnesses, diseases, or disorders? (**If yes, please list what they are and who has/had them**)
14. What are your health and fitness goals?
15. Do you have a specific time frame to reach your goals?
16. Is there anything holding you back from reaching your goals? Please be specific.
17. What is your biggest hurdle preventing you have from reaching your goal?
18. On a scale from 1 to 10, how willing are you to change habits that may be inhibiting you from reaching your goals?
19. On a scale from 1 to 10, how important is it to you to reach your goals?
20. On a scale from 1 to 10, how motivated are you?
21. Are there any specific areas you would like to focus on? (**please list in the order most important first**)

Nutrition Assessment

1. How would you describe your relationship with food?
How many meals per day do you eat (including all feedings)?
2. Do you binge eat? If so, what are your cravings?
3. Do you have specific times of day you eat? When is your first and last meal?
4. What food allergies do you have? Do you avoid them or eat them and how often?
5. Do you bloat or have any discomfort after eating?
6. How much water do you drink daily?
7. Do you have low energy?
8. Do you drink caffeine? How much do you have per day?
9. Do you drink alcohol? If so, how many times per week?
10. Do you have stress or anxiety? Do you handle it well (what do you do)?
11. Have you experienced any bodily changes in a short period of time unrelated to physical activity?
12. Are you taking any supplements/vitamins of any kind? Please list them, dosing, and if you noticed any change while on them?
13. How would you describe your sleep quality? How many hours per night?

EMS Suit and Fitness Area Questions

1. What size are you (top & bottom) if you were to wear workout clothes tight?
2. What is your height and weight?
3. Which area in your house would you like to use for the training session or will we be outside for our training session?
4. Do you have a counter top or floor space where I can put my towel down to wet the electropads on the ems suit?
5. Do you have any fitness equipment? If so, please let me know exactly so that I can know what equipment to bring for our session.
6. Will there be any stairs or elevator to get into your home?
7. Is there a gate code that I will need to get into the apartment or home?
8. Is there wifi in your home?

Basic Information

1. Height:
2. Weight:
3. Birthdate:
4. Email Address:
5. Home Address:
6. Desired days and times for your training sessions: