



PERSONAL TRAINING APPLICATION FORM

CONTACT DETAILS

NAME:

EMAIL:

PHONE NUMBER:

AGE

GENDER
M/F

HEIGHT

FITNESS GOALS

WHAT IS YOUR CURRENT BODY WEIGHT?

	KG	<input type="checkbox"/>
	STONE	<input type="checkbox"/>

DO YOU HAVE AN IDEAL OR TARGET BODY WEIGHT?

	KG	<input type="checkbox"/>
	STONE	<input type="checkbox"/>

PLEASE RANK IN ORDER OF IMPORTANCE FROM 1 TO 7 (1 BEING MOST & 7 BEING LEAST)

FAT LOSS		INCREASED MUSCLE MASS / DEFINITION	
WEIGHT GAIN		IMPROVE STRENGTH	
IMPROVED CARDIOVASCULAR HEALTH		SPORTS PERFORMANCE	
IMPROVED HEALTH			

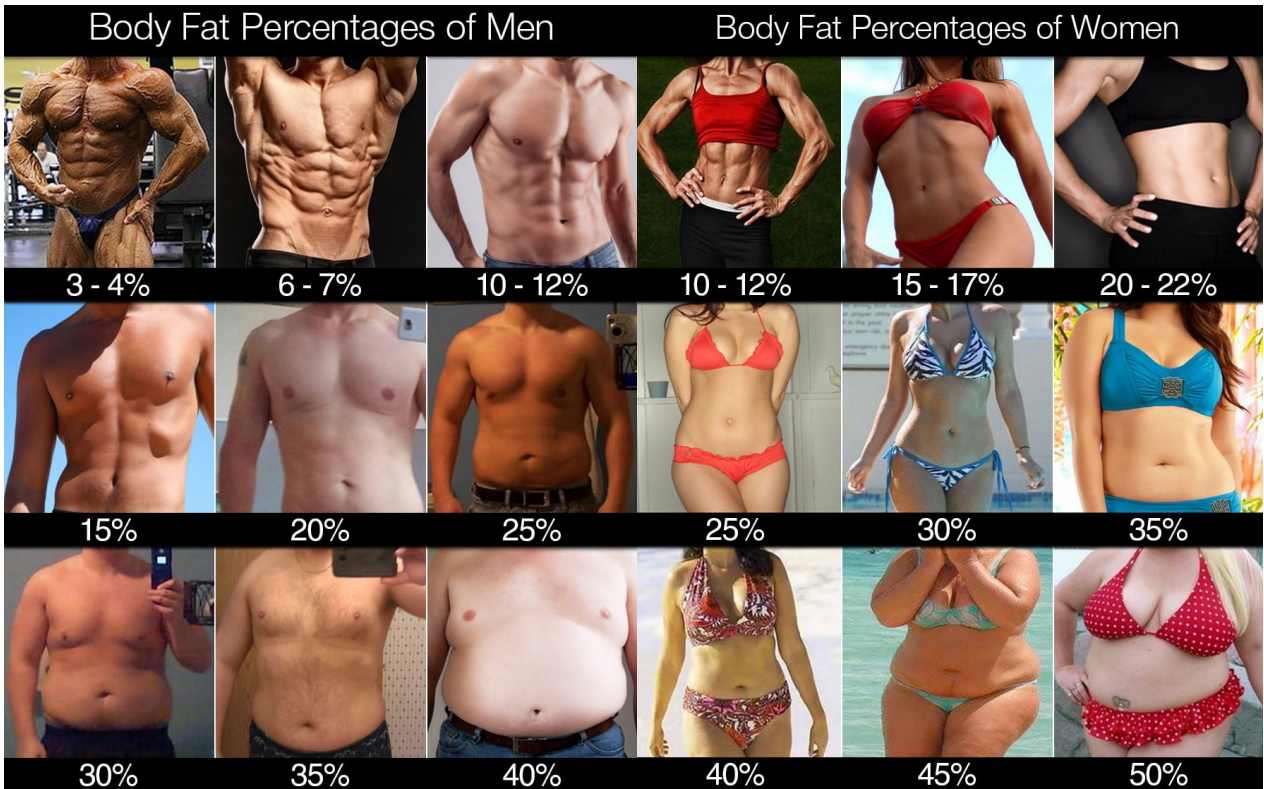
PLEASE STATE YOUR SPECIFIC GOALS
(ie: areas you want to improve, how you want to feel)

DO YOU HAVE A SPECIFIC DATE OR TIME FRAME TO MEET THESE GOALS?

PLEASE TICK WHICH FORM OF PROGRESS IS MOST IMPORTANT TO YOU

IMMEDIATE PROGRESS THAT'S HARDER TO MAINTAIN	
MAINTAINABLE PROGRESS THAT MAY BE A SLOWER RATE	

PHYSIQUE GOALS



WHERE DO YOU FEEL YOUR CURRENT STATUS IS IN TERMS OF BODY FAT IN RELATION TO THE CHART ABOVE?

%

WHAT WOULD BE YOUR IDEAL BODY FAT TARGET IN RELATION TO THE CHART ABOVE?

%

WHICH MUSCLE GROUPS DO YOU WANT TO IMPROVE THE MOST?

RANK IN ORDER OF IMPORTANCE FROM 1-7

ARMS (SHOULDERS, BICEP & TRICEPS)		GLUTES (BUM)	
BACK		HIPS	
STOMACH		CHEST	
LEGS			

INJURY HISTORY

DO YOU HAVE ANY CURRENT OR PREVIOUS INJURIES?

YES NO

IF YES, PLEASE DETAIL BELOW?

[Empty text box for injury details]

DO ANY MOVEMENTS OR EXERCISES CAUSE YOU PAIN OR DISCOMFORT?

IF YES, PLEASE DETAIL BELOW?

[Empty text box for movement/exercise details]

DIET HABITS

HOW MANY MEALS DO YOU HAVE A DAY?

1-2 3-4 5-6

DO YOU EAT BREAKFAST?

NO 1-2x A WEEK 3-4x A WEEK 5-6x A WEEK EVERYDAY

HOW MUCH TIME DO YOU HAVE FOR BREAKFAST BEFORE WORK?

NONE 5-10 mins 10-15 mins 15-20 mins 20-30 mins

WHAT WOULD YOU NORMALLY EAT FOR BREAKFAST?

LIST THE 3 MOST COMMON THINGS YOU WOULD EAT FOR BREAKFAST

Table with 3 rows and 2 columns for listing breakfast items.

DO YOU PREPARE YOUR OWN LUNCH OR BUY ON THE GO?

I PREP MY OWN LUNCH I BUY ON THE GO

LIST BELOW THE 5 MOST COMMON PLACES YOU WOULD USUALLY GO TO BUY LUNCH AND WHAT YOU WOULD USUALLY GET?

PLEASE NOTE BELOW.

I'D USUALLY GO TO...	AND GET ...
(example) Pret	Crayfish and Avocado Salad, apple and small coconut milk latte

HOW MANY DAYS A WEEK DO YOU COOK DINNER AT HOME?

0-1 2-3 4-5 5-7

HOW MANY TIMES DO YOU EAT OUT OR GET TAKE AWAY A WEEK?

0-1 2-3 4-5 5-7 8+

LIST YOUR 3 MOST COMMON TAKEAWAYS & WHAT YOU WOULD ORDER.

	(EXAMPLE) INDIAN	Chicken korma, pilau rice, naan bread 1 pint of beer.
1		
2		
3		

WHICH WOULD YOU SAY BEST DESCRIBES YOUR RELATIONSHIP WITH COOKING?

TICK THE BOXES THAT BEST DESCRIBE YOUR CURRENT HABITS.

I DON'T COOK / MY PARTNER COOKS	<input type="checkbox"/>	I'M TOO TIRED TO MAKE DINNER	<input type="checkbox"/>
I RATHER NOT COOK	<input type="checkbox"/>	I ENJOY COOKING	<input type="checkbox"/>
I DON'T HAVE TIME TO MAKE LUNCH	<input type="checkbox"/>	I RATHER MAKE MY OWN MEALS	<input type="checkbox"/>
I WOULDN'T EAT A READY MEAL	<input type="checkbox"/>	I RATHER EAT A READY MEAL THAN COOK	<input type="checkbox"/>

WHICH WOULD YOU SAY BEST DESCRIBES YOUR SNACKING HABITS?

TICK THE BOXES THAT BEST DESCRIBE YOUR CURRENT HABITS.

I PREFER TO SNACK OVER EATING MEALS	<input type="checkbox"/>	I SNACK BETWEEN EVERY MEAL	<input type="checkbox"/>
I SNACK OFTEN AT WORK	<input type="checkbox"/>	I SNACK 1-2x A DAY	<input type="checkbox"/>
I SNACK OFTEN AT NIGHT/BEFORE BED	<input type="checkbox"/>	I DON'T SNACK BETWEEN MEALS	<input type="checkbox"/>

LIST UP TO 5 OF YOUR FAVOURITE SWEET TREATS OR JUNK FOODS THAT WOULD BE IN YOUR IDEAL DIET PLAN.

(BE HONEST SO THAT YOUR DIET IS SUSTAINABLE!)

Eg.	Pizza, Burgers, Ice Cream, Chocolate, Cake.
1	
2	
3	
4	
5	

DOES ANYTHING BELOW BEST DESCRIBE YOUR EATING HABITS?

TICK ONE BELOW.

I CAN EAT A LITTLE AND LEAVE THE REST.	<input type="checkbox"/>
IF I EAT A BIT I'LL FINISH THE WHOLE LOT.	<input type="checkbox"/>

HAVE YOU HAD SUCCESS WITH A DIET PLAN BEFORE?

YES NO

IF YES, PLEASE DETAIL BELOW?

IF YES, WHY WAS YOU UNABLE TO SUSTAIN THAT SUCCESS?

WHAT DO YOU FIND HARDEST ABOUT STICKING TO A DIET PLAN?

PLEASE TICK BELOW.

ORGANISING MY MEALS	<input type="checkbox"/>	I EAT OUT TOO OFTEN	<input type="checkbox"/>
KNOWING WHERE TO GET MY MEALS FROM	<input type="checkbox"/>	I SOCIALISE TOO OFTEN	<input type="checkbox"/>
NOT ENJOYING THE FOOD ON THE PLAN	<input type="checkbox"/>	DIET PLANS ARE TOO STRICT	<input type="checkbox"/>

NOTE ANY OTHER REASON IN THE BOX BELOW.

WHY DO YOU FEEL YOU ARE STRUGGLING TO LOSE WEIGHT OR MAKE PROGRESS WITH YOUR CURRENT EATING HABITS?

PLEASE TICK BELOW.

I EAT TOO MUCH		FOOD I EAT AFTER DRINKING ALCOHOL	
I DRINK TOO MUCH		I EAT OUT TOO OFTEN	
I SNACK TOO MUCH		MY SWEET TOOTH	
MY PORTIONS ARE TOO BIG		I DON'T EXERCISE ENOUGH	
I'M EITHER ALL OR NOTHING		I HAVE NO IDEA WHY	

NOTE ANY OTHER REASON IN THE BOX BELOW.

DO YOU HAVE ANY FOOD ALLERGIES OR INTOLERANCE?

PLEASE TICK BELOW

DAIRY/LACTOSE		EGGS	
GLUTEN		FISH	
NUTS		SOY	
SHELLFISH		OTHER	

IF OTHER, PLEASE DETAIL BELOW

DO YOU CURRENTLY USE ANY SUPPLEMENTS LIKE MULTI VITAMINS OR PROTEIN POWDER?

YES NO

WOULD YOU BEEN OPEN TO USING MULTI VITAMINS OR PROTEIN POWDER IF YOUR DIET REQUIRES IT?

YES NO

WHICH ARE YOUR PREFERRED SOURCES OF PROTEIN?

TICK FROM THE LIST BELOW

RED MEAT		PORK & POULTRY		FISH		VEGETERIAN	
GROUND BEEF		CHICKEN BREAST		SALMON FILLET		SOY	
STEAK		CHICKEN THIGHS		SMOKED SALMON		EGGS	
DICED BEEF		CHICKEN LEG		COD		CHEESE	
DICED LAMB		CHICKEN SAUSAGES		HADDOCK		YOGURT	
LAMB STEAKS		TURKEY BREAST		TUNA STEAK		RED KIDNEY BEANS	
GROUND LAMB		TURKEY LEG		TUNA (TINNED)		BLACK BEANS	
LAMB SHOULDER		TURKEY SAUSAGES		SALMON (TINNED)		PINTO BEANS	
LAMB LEG		GROUND TURKEY		SARDINES		CHICK PEAS	
		PORK LOIN		PRAWNS			
		PORK BELLY		SEA BASS			
		PORK SAUSAGES		SEA BREAM			

WHICH ARE YOUR PREFERRED CARBOHYDRATES, FRUITS & VEGETABLES?

TICK FROM THE LIST BELOW

CARBS		VEGETABLES			FRUIT	
RICE		BROCCOLI		CUCUMBER		APPLE
PASTA		CARROTS		PEPPERS		ORANGE
POTATO		CAULIFLOWER		KALE		BANANA
SWEET POTATO		CORN		MUSHROOMS		PEAR
QUINOA		PEAS		SALAD GREENS		PLUMS
LENTILS		GREEN BEANS		TOMATOES		NECTERINE
BEANS		PAK CHOI		AVOCADO		PEACH
PUMPKIN		SPINACH		MANGE TOUT		BERRIES
SQUASH		ONIONS		ASPARAGUS		MELON
BREAD		ASPARAGUS		MUSHROOMS		GRAPES
OATS		AUBERGINES		BEETROOT		PINEAPPLE
		CABBAGE		SAURKRAUT		MANGO
		CELERY		KIMCHI		KIWI

ALCOHOL CONSUMPTION

HOW MUCH ALCOHOL DO YOU CONSUME?

TICK THE BOX BELOW

MONDAY - THURSDAY

<input type="checkbox"/>	NONE
<input type="checkbox"/>	1-2 DRINKS
<input type="checkbox"/>	3-5 DRINKS
<input type="checkbox"/>	6+ DRINKS

FRIDAY - SUNDAY

<input type="checkbox"/>	NONE
<input type="checkbox"/>	1-2 DRINKS
<input type="checkbox"/>	3-5 DRINKS
<input type="checkbox"/>	6-9 DRINKS
<input type="checkbox"/>	10+ DRINKS

WHAT IS YOUR PREFERRED ALCOHOL OF CHOICE?

TICK THE BOXES BELOW

<input type="checkbox"/>	BEER / CIDER
<input type="checkbox"/>	WINE
<input type="checkbox"/>	SPIRITS
<input type="checkbox"/>	SPIRIT & MIXER
<input type="checkbox"/>	CHAMPAGNE

WHAT ACTIVITIES BEST DESCRIBES YOUR AVERAGE WEEKEND?

TICK FROM THE BOXES BELOW

<input type="checkbox"/>	DINNER WITH FRIENDS	<input type="checkbox"/>	WEIGHT TRAINING / GYM
<input type="checkbox"/>	PARTYING/DRINKING HEAVILY	<input type="checkbox"/>	FITNESS CLASS (SPIN, CIRCUIT ETC)
<input type="checkbox"/>	NORMAL ROUTINE (SAME AS MIDWEEK)	<input type="checkbox"/>	MOVIE & SNACKS
<input type="checkbox"/>	SOCIAL DRINKS WITH FRIENDS	<input type="checkbox"/>	

READINESS FOR COMMITMENT

HOW MANY DAYS A WEEK ARE YOU WILLING TO COMMIT TO EXERCISE?

1x 2x 3x 4x 5x

HOW MUCH TIME CAN YOU COMMIT TO WORKOUT SESSIONS?

30mins 45mins 60mins

DO YOU HAVE ANY CONCERNS OR COMMITMENTS THAT COULD REGULARLY INTERFERE WITH YOUR EXERCISE PROGRAMME?

PLEASE DETAIL BELOW

HAVE YOU EVER STRUGGLED TO STICK TO A FITNESS PROGRAMME BEFORE?

YES NO

IF YES, PLEASE DETAIL WHY BELOW

NON EXERCISE ACTIVITY

WHAT DO YOU DO FOR A LIVING?

HOW LONG ON AVERAGE DO YOU SPEND AT WORK?

6-8 HOURS 8-10 HOURS 10-12 HOURS 12-14 HOURS 14+ HOURS

HOW WOULD YOU BEST DESCRIBE YOUR JOBS ACTIVITY LEVEL?

<input type="checkbox"/>	SEDENTARY (DESK BASED WORK)
<input type="checkbox"/>	LIGHTLY ACTIVE (SALES ASSISTANT)
<input type="checkbox"/>	HIGHLY ACTIVE (POSTMAN, SCAFFOLDER, BRICK LAYER, ETC)

IF KNOWN, HOW MANY STEPS DO YOU COMPLETE ON AVERAGE DAILY?

TICK THE BOX BELOW

<input type="checkbox"/>	< 3000 STEPS
<input type="checkbox"/>	< 5000 STEPS
<input type="checkbox"/>	< 8000 STEPS
<input type="checkbox"/>	< 10000 STEPS
<input type="checkbox"/>	< 12000 STEPS
<input type="checkbox"/>	15000+ STEPS
<input type="checkbox"/>	I HAVE NO IDEA

HOW DO YOU GET TO WORK?

TICK THE BOX BELOW

<input type="checkbox"/>	I DRIVE TO WORK
<input type="checkbox"/>	I DRIVE TO THE STATION AND GET THE TRAIN/BUS
<input type="checkbox"/>	I WALK TO THE STATION AND GET TRAIN/BUS
<input type="checkbox"/>	I WALK TO WORK

DO YOU HAVE ANY KIND OF EXTRA OR SPORTS BASED ACTIVITY OTHER THAN GYM/ HOME WORKOUTS? (ie. walking dog, football, biking, indoor climbing)

YES NO

IF YES, PLEASE DETAIL BELOW

ENERGY LEVELS

WHEN ARE YOUR ENERGY LEVELS THE HIGHEST?

6-9am 10am-12pm 1-3pm 4-6pm 7-9pm 10pm-12am

WHEN ARE YOUR ENERGY LEVELS THE LOWEST?

6-9am 10am-12pm 1-3pm 4-6pm 7-9pm 10pm-12am

HOW MANY CUPS OF TEA OR COFFEE DO YOU DRINK A DAY?

1-2 3-4 5+

SLEEP QUALITY

HOW MANY HOURS SLEEP A NIGHT DO YOU GET ON AVERAGE?

1-3 HOURS 4-5 HOURS 6-8 HOURS

SLEEP QUALITY QUESTIONS	YES	NO
DO YOU HAVE TROUBLE FALLING ASLEEP AT NIGHT?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE DIFFICULTY WAKING UP IN THE MORNING?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU SLEEP LESS THAN 8-9 HOURS A NIGHT?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU WAKE UP ONCE OR MORE IN THE NIGHT?	<input type="checkbox"/>	<input type="checkbox"/>

IF YES, AT WHAT TIMES WOULD YOU WAKE AT NIGHT?

1-3am 3-5am wake up tired between 5-8am wake up many times through the night

DO YOU SLEEP WITH ANY LIGHT OR NOISE (ie. leave on the tv)?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU WAKE UP FEELING TIRED OR DRAINED?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU GO TO BED LATER THAN 11PM?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU STRUGGLE TO GET BACK TO SLEEP IF YOU WAKE DURING THE NIGHT?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU GET UP TO START THE DAY EARLIER THAN 6AM?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU USE ANY MEDICATION TO HELP YOU SLEEP?	<input type="checkbox"/>	<input type="checkbox"/>
WOULD YOU BE WILLING TO USE NATURAL SUPPLEMENTS TO IMPROVE SLEEP?	<input type="checkbox"/>	<input type="checkbox"/>

STRESS MANAGEMENT

WHAT WOULD YOU RATE YOUR DAILY STRESS ON AVERAGE LEVELS BETWEEN 1 - 10?

1 BEING VERY LOW, 10 BEING VERY HIGH.

STRESS MANAGEMENT QUESTIONS	YES	NO
IS THE BULK OF YOUR STRESS WORK RELATED?		
IS THE BULK OF YOUR STRESS FAMILY/PERSONAL ISSUES?		
DO YOU STRUGGLE TO SLEEP DUE TO STRESS?		
DO YOU WAKE UP FEELING STRESSED?		
DO YOU ANSWER/SEND WORK RELATED EMAILS BEFORE BED?		
WOULD YOU BE WILLING TO USE NATURAL SUPPLEMENTS TO DECREASE STRESS?		
ARE YOU ON MEDICATION FOR STRESS RELATED ISSUES?		

IF ON ANY MEDICATION FOR STRESS, PLEASE DETAIL BELOW

DIGESTIVE SYSTEM

DO YOU SUFFER FROM	YES	NO
INDIGESTION OR HEART BURN?		
GAS OR BELCHING?		
CONSTIPATION?		
DIARRHEA OR LOOSE STOOLS?		
DO YOU HAVE LESS THAN ONE BOWEL MOVEMENT A DAY?		
DO YOU HAVE A SENSE OF FULLNESS AFTER MEALS?		
DO YOU SUFFER FROM BLOATING 1 HOUR AFTER EATING?		
WOULD YOU BE WILLING TO CHANGE YOUR DIET TO IMPROVE THESE ISSUES?		
WOULD YOU BE WILLING TO USE SUPPLEMENTS TO IMPROVE THESE ISSUES?		

MEDICAL HEALTH

DO YOU HAVE ANY DIAGNOSED HEALTH CONDITIONS?
(example: asthma, high/low blood pressure, under or over active thyroid)
PLEASE LIST BELOW:

IF YOU ARE ON ANY MEDICATION FOR HEALTH RELATED ISSUES?
(example: blood pressure tablets)
PLEASE LIST BELOW:

DONE!

Thank you for completing the questionnaire.

By taking the time to complete this questionnaire I now have everything I need to assess your goals, lifestyle and habits so that we can get the ball rolling, set expectations and change your physique and health for the better.

Please save and send this PDF directly to me at:
nathan@nsjcoaching.com

Once I have assessed your application form I'll be in touch with the key plan of action to move forward.

Thanks again for taking this huge step forward and for having the courage to reach out for help to change your life,

Nathan Jordine

