

# Lodestar Integrated Training LLC

## Client Intake & Health Questionnaire



Please complete the following forms prior to your first training session.

Joe Irwin Jr.  
Personal Training | In-Home & Private Gyms  
North Fork, NY

631-946-1136 | [lit.integrated@gmail.com](mailto:lit.integrated@gmail.com)  
[@lodestar\\_fitness](mailto:@lodestar_fitness) | [www.lodestar-training.com](http://www.lodestar-training.com)

# PAR-Q+ (Physical Activity Readiness Questionnaire)

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer **YES** or **NO** to the following questions.

1. Has your doctor ever said that you have a **heart condition** and should only perform physical activity recommended by a doctor?

Yes  No

2. Do you feel **pain in your chest** when performing physical activity?

Yes  No

3. In the past month, have you had **chest pain when not exercising**?

Yes  No

4. Do you **lose balance because of dizziness** or ever lose consciousness?

Yes  No

5. Do you have a **bone or joint problem** that could be worsened by exercise?

Yes  No

6. Is your doctor currently prescribing **medication for blood pressure or a heart condition**?

Yes  No

7. Do you know of **any other reason** you should not participate in physical activity?

Yes  No

**If you answered YES to any question, medical clearance may be recommended before beginning exercise.**

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Health History Questionnaire

## Client Information

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

---

## Medical History

Do you currently have or have you previously had:

- Heart disease
- High blood pressure
- Diabetes
- High cholesterol
- Asthma or respiratory conditions
- Arthritis
- Chronic back pain
- Joint injuries
- Surgery

Please describe any conditions:

---

---

## Current Medications

List any medications you are currently taking:

---

---

## Injuries or Physical Limitations

Please describe any injuries or movement limitations:

---

---

## Exercise History

Do you currently exercise?

Yes  No

If yes, what type of exercise?

---

---

**Physician Information**

Doctor's Name: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

## Liability Waiver

I understand that participation in **personal training and exercise programs** involves inherent risks including injury, illness, or physical strain.

I voluntarily agree to participate in exercise sessions conducted by **Lodestar Integrated Training LLC** and understand that I am responsible for monitoring my own physical condition during exercise.

I hereby release and hold harmless **Joseph Irwin Jr., NASM-CPT**, and Lodestar Integrated Training from any liability arising from participation in training sessions, except in cases of gross negligence.

I acknowledge that exercise participation is voluntary and I assume all risks associated with physical activity.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Trainer Signature: \_\_\_\_\_

## Informed Consent

I understand that:

- Personal training includes physical activity such as strength training, cardiovascular exercise, mobility training, and functional movement.
- There are potential risks associated with physical exercise.
- I have the right to stop exercise at any time.

I agree to inform the trainer of:

- Pain or discomfort
- Dizziness
- Shortness of breath
- Any unusual symptoms

I understand that the trainer is **not a physician or medical professional** and cannot diagnose or treat medical conditions.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Emergency Contact Form

Client Name: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Contact (Optional): \_\_\_\_\_

Medical Conditions Trainer Should Know:

# Lifestyle Questionnaire

## Daily Activity Level

Occupation:

- Sedentary
  - Moderately active
  - Very active
- 

## Sleep

Average hours of sleep per night:

- 4–5
- 6–7
- 7–9

Sleep quality:

- Poor
  - Average
  - Good
- 

## Stress Levels

Rate daily stress:

- Low
- Moderate
- High

Primary sources of stress:

---

---

### **Nutrition Habits**

How many meals do you typically eat per day?

- 1–2
- 3
- 4+

Do you follow a specific diet?

- No
- Yes

If yes, describe:

---

---

### **Fitness Goals**

What are your main goals?

- Weight loss
- Strength
- Mobility
- Athletic performance
- Injury prevention
- General health

### **Availability**

How many days per week can you realistically train?

- 1–2
- 3–4
- 5+

Preferred training times: