
Specialist in Fitness Nutrition

# Client Forms and Handouts

# Physical Activity Readiness Questionnaire

## A Questionnaire for People Aged 15 to 69

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.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the Physical Activity Readiness Questionnaire (PAR-Q) will tell you if you should check with your doctor before you start. If you are over 69 years of age and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

| YES | NO | |
|---|---|---|
| ❑ | ❑ | 1. Has your doctor ever said that you have a heart condition *and* that you should only do physical activity recommended by a doctor? |
| ❑ | ❑ | 2. Do you feel pain in your chest when you do physical activity? |
| ❑ | ❑ | 3. In the past month, have you had chest pain when you were not doing physical activity? |
| ❑ | ❑ | 4. Do you lose your balance because of dizziness, or do you ever lose consciousness? |
| ❑ | ❑ | 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? |
| ❑ | ❑ | 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? |
| ❑ | ❑ | 7. Do you know of any other reason why you should not do physical activity? |

**if you answered**

### **YES** to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- ❑ You may be able to do any activity you want—as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those that are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- ❑ Find out which community programs are safe and helpful for you.

### **NO** to all questions

If you answered NO honestly to *all* PAR-Q questions, you can be reasonably sure that you can:

- ❑ Start becoming much more physically active—begin slowly and build up gradually. This is the safest and easiest way to go.
- ❑ Take part in a fitness appraisal—this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

### DELAY BECOMING MUCH MORE ACTIVE:

- ❑ If you are not feeling well because of a temporary illness such as a cold or a fever—wait until you feel better; or
- ❑ If you are or may be pregnant—talk to your doctor before you start becoming more active

**PLEASE NOTE:** If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.



NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME: _____

SIGNATURE: _____ DATE: _____

SIGNATURE OF PARENT: _____ WITNESS: _____
or GUARDIAN (for participants under the age of majority)

**NOTE: This physical activity clearance is valid for a maximum of 12 months form the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.**

ParQ_SPN_0807

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# Medical History and Present Medical Condition Questionnaire



| Name | Date |
|---|---|

In order for you to gain the most benefit from this program, we encourage you to answer all of the following questions. If you are uncomfortable with answering a particular question, feel free to leave it blank. Please explain all YES answers at the end of this questionnaire.

## PERSONAL MEDICAL HISTORY

Have you have ever had any of the following conditions?

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| | | 1. Allergies | | | 11. Ulcer | | | 21. Loss of consciousness |
| | | 2. Loss of hearing | | | 12. Heart attack | | | 22. Epilepsy |
| | | 3. Asthma | | | 13. Heart murmur | | | 23. Convulsions/seizures |
| | | 4. Kidney disease | | | 14. Positive stress test | | | 24. Stroke |
| | | 5. Prostatitis | | | 15. Heart valve abnormality | | | 25. Diabetes |
| | | 6. Colitis | | | 16. Angina | | | 26. Thyroid trouble |
| | | 7. Hepatitis | | | 17. Heart failure | | | 27. Anemia |
| | | 8. Liver disease | | | 18. High cholesterol | | | 28. Eczema |
| | | 9. Elevated liver enzyme test | | | 19. High blood pressure | | | 29. Cancer (including skin cancer) |
| | | 10. Pancreatitis | | | 20. Arthritis/Rheumatism | | | 30. Sleep apnea |

## REVIEW OF SYMPTOMS

Do you currently have or have you recently had any of the following?

| **EYES, EARS, NOSE, THROAT** | | | **PULMONARY** | | | **GENITO-URINARY** | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | | Y | N | | Y | N | |
| | | 31. Difficulty with night vision | | | 40. Shortness of breath | | | 45. Bladder trouble |
| | | 32. Change in vision | | | 41. Chronic or frequent cough | | | 46. Blood in urine |
| | | 33. Blurred or double vision | | | 42. Brown/Blood-tinged sputum | | | 47. Irregular vaginal bleeding |
| | | 34. Bleeding gums | | | 43. Chest tightness | | | 48. Currently pregnant |
| | | 35. Frequent nosebleeds | | | 44. Wheezing | | | 49. Difficulty starting or stopping urination |
| | | 36. Frequent sinus trouble | | | | | | |
| | | 37. Recent Hoarseness | | | | | | 50. Urinating 3 times per night |
| | | 38. Ringing/Buzzing ears | | | | | | 51. Frequent or painful urination |
| | | 39. Earaches | | | | | | 52. Problems with sexual function |
| **GASTROINTESTINAL** | | | **CENTRAL NERVOUS SYSTEM** | | | **HEART/VASCULAR** | | |
| Y | N | | Y | N | | Y | N | |
| | | 53. Vomited blood | | | 63. Fainting spells | | | 71. Palpitation (irregular heartbeat) |
| | | 54. Persistent diarrhea | | | 64. Recurrent dizziness | | | 72. Pain or discomfort in chest |
| | | 55. Persistent constipation | | | 65. Frequent headaches | | | 73. High cholesterol |
| | | 56. Frequent abdominal pain | | | 66. Tremors | | | 74. Swelling of feet |
| | | 57. Frequent nausea | | | 67. Memory loss | | | 75. Leg pain while walking |
| | | 58. Frequent indigestion/heartburn | | | 68. Loss of coordination | | | 76. Painful varicose veins |
| | | 59. Black/Bloody bowel movement | | | 69. Difficulty concentrating | | | |
| | | 60. Hemorrhoids | | | 70. Numbness/Tingling extremities | | | |
| | | 61. Trouble swallowing | | | | | | |
| | | 62. Hernia | | | | | | |
| **MUSCULOSKELETAL.** | | | **MISCELLANEOUS** | | | | | |
| Y | N | | Y | N | | Y | N | |
| | | 77. Back trouble/pain | | | 81. Bleeding/Bruising easily | | | 86. Night sweats |
| | | 78. Neck trouble/pain | | | 82. Enlarged glands | | | 87. Undesired weight loss |
| | | 79. Joint injury/pain/swelling | | | 83. Rashes | | | 88. Snoring |
| | | 80. Carpal tunnel syndrome | | | 84. Unexplained lumps | | | 89. Difficulty sleeping |
| | | | | | 85. Chronic fatigue | | | 90. Low blood sugar |

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# Medical History and Present Medical Condition Questionnaire



Name

**ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS**

Please answer the following questions honestly:

| Y | N | |
|---|---|---|
| | | 91. Are you experiencing any stresses, mood problems, relationship difficulties, or substance-related problems for which you would like resource or referral information on a confidential basis? |
| | | 92. Do you occasionally use or are you currently taking any prescription or over-the-counter medications? List name, dosage, and the reason the medication is used on the next page. |
| | | 93. Have you had any surgical operations in the last 10 years? |
| | | 94. Has anyone in your immediate family developed heart disease before the age of 60? |
| | | 95. Do any diseases run in your family? |
| | | 96. Do you currently have a cold/cough, or have you had any in the last two weeks? |
| | | 97. Have you ever been hospitalized? If yes, list date, length of stay, and reason on the next page. |
| | | 98. Are you currently under a doctor's care? If yes, please describe what you are being treated for on the next page. |
| | | 99. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year? |
| | | 100. Do you have any special concerns regarding your health that you would like to discuss with the doctor? |
| | | 101. Are you a current cigarette smoker?<br>A. How many packs of cigarettes do you smoke a day? _____<br>B. How long have you been smoking? _____ |
| | | 102. Are you an ex-smoker?<br>A. How many years did you smoke? _____<br>B. How many packs a day? _____<br>C. When did you quit? _____ |

103. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

104. I drink ____ beers _____ ounces of hard liquor _____ ounces of wine per week.

105. When were your most recent immunizations? Tetanus _____ Flu shot _____ Pneumovax _____

106. When were you most recent health maintenance screening tests?

Cholesterol _____ Results? _____ PSA (Prostate) _____ Results? _____ Mammogram _____ Results? _____

Sigmoidoscopy _____ Results? _____ Pap Smear _____ Results? _____

107. Describe any hobbies or recreational activities that have exposed you to noise, chemicals, or dust:

108. Please describe typical weekly exercise or physical activities including any exercise at work:

109. My current diet could be best characterized as (check all that apply):

____ Low fat ___ Low carb ___ High protein ___ Vegetarian/Vegan ____No special diet

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# Medical History and Present Medical Condition Questionnaire



Name

Please Explain All YES Answers Here. List the question number, and add details.

| QUESTION NUMBER | DETAILS AND DATES OF OCCURRENCE |
|---|---|
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# Comprehensive Client Information Sheet



| Name | Date |
|---|---|

**Instructions**
This is your comprehensive client information sheet. With this sheet, we will ask you to provide some relevant personal information. The answers to these questions are essential in order to allow us to design an optimized individual fitness program for you. **Please answer all questions** in the most accurate manner possible while being as concise as possible.

**Disclaimer**
Please recognize the fact that it is **your responsibility** to work directly with your physician before, during, and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

## Basic Information

| 1) What is your gender? | 2) What is your age? | 3) What is your date of birth (month/day/year)? |
|---|---|---|
| 4) What is your height? | 5) What is your weight (measured as of this morning)? | |

6) What is your body fat percentage (have this taken *before* submitting this sheet)?

| 7) Please provide the following skinfold measures (mm). | | | | 8) Please provide the following girth measurements (in or cm). | | | |
|---|---|---|---|---|---|---|---|
| Abs | | Subscapular | | Neck | | Chest | |
| Triceps | | Suprailiac | | Shoulder | | Biceps | |
| Chest | | Thigh | | Waist | | Hips | |
| Mid-axillary | | | | Thigh | | Calf | |

9) What are your specific goals (rank these goals according to importance with 1 being the most important and 8 being the least)?

| | | | |
|---|---|---|---|
| Improved health | Improved endurance | Increased muscle mass | Fat loss |
| Increased strength | Sport specific* | Increased power | Weight gain |

*Please provide the sport or athletic event you are training for:

10) Is there a specific timeline for achieving a specific goal?

11) Circle which of the two are of greater importance:
a. Immediate progress that's less easily maintained b. Maintainable progress that may not be as rapid

Please explain:

## Exercise Information

12) Rate your ability in the following exercises (check the box that corresponds with your ability):

| Exercises: | Advanced | Intermediate | Novice | Unfamiliar |
|---|---|---|---|---|
| Compound movements | | | | |
| Barbell squats | | | | |
| Barbell deadlift | | | | |
| Barbell bench press | | | | |
| Bent-over barbell row | | | | |
| Barbell Shoulder Press | | | | |
| Pull-up | | | | |
| Barbell hack squat | | | | |
| Olympic movements | | | | |
| Snatch | | | | |
| Clean | | | | |

13) Are you currently exercising regularly (at least 3x per week)? circle one
YES If you answered YES, continue on to question 14.
NO If you answer NO, continue on to question 18.

14) How long have you been consistently doing so without a break?

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# Comprehensive Client Information Sheet



Name

15) On the following chart, fill in which type of exercise you normally perform each day: resistance training (RT); interval cardio bouts (ICB); low-intensity cardio bouts (LICB); sport-specific work (SSW)

| Day | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Type of Exercise | | | | | | | |

16) On the following chart, fill in your approximate workout duration for each day (in minutes).

| Day | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Duration | | | | | | | |

17) Please submit your current exercise regimen along with this form (type it up or write it out for us). Please skip to question 19.

18) If you are not currently exercising regularly, have you ever been on a consistent exercise plan (at least 3x per week)? circle one

YES If you answered YES, how long ago was it, and how long did it last? _____

NO

**Lifestyle Information**

19) What do you do for a living?

20) What is the activity level at your job? None Moderate High

21) Does your job entail shift work? Y N

22) If you follow a more regular schedule, when do you work? Days Afternoons Nights

23) How often do you travel? Rarely Few times per year Few times per month Weekly

24) Please list the physical activities that you participate in outside of the gym and outside of work.

25) If you have any diagnosed health problems, list the condition(s).

26) If you are on any medications, please list them.

27) What additional therapies or interventions are being undertaken for the given health problem(s)?

28) If you have any injuries, please list them.

29) What additional therapies or interventions are being undertaken for the given injury(s)?

30) Please fill out the following timetable with your most normal daily schedule listing the time you wake up, work and have breaks, work out and go to sleep.

| A.M. | | | | P.M. | | | |
|---|---|---|---|---|---|---|---|
| 12:00 – 12:30 | | 6:00 – 6:30 | | 12:00 – 12:30 | | 6:00 – 6:30 | |
| 12:30 – 1:00 | | 6:30 – 7:00 | | 12:30 – 1:00 | | 6:30 – 7:00 | |
| 1:00 – 1:30 | | 7:00 – 7:30 | | 1:00 – 1:30 | | 7:00 – 7:30 | |
| 1:30 – 2:00 | | 7:30 – 8:30 | | 1:30 – 2:00 | | 7:30 – 8:30 | |
| 2:00 – 2:30 | | 8:00 – 8:30 | | 2:00 – 2:30 | | 8:00 – 8:30 | |
| 2:30 – 3:00 | | 8:30 – 9:00 | | 2:30 – 3:00 | | 8:30 – 9:00 | |
| 3:00 – 3:30 | | 9:00 – 9:30 | | 3:00 – 3:30 | | 9:00 – 9:30 | |
| 3:30 – 4:00 | | 9:30 – 10:00 | | 3:30 – 4:00 | | 9:30 – 10:00 | |
| 4:00 – 4:30 | | 10:00 – 10:30 | | 4:00 – 4:30 | | 10:00 – 10:30 | |
| 4:30 – 5:00 | | 10:30 – 11:00 | | 4:30 – 5:00 | | 10:30 – 11:00 | |
| 5:00 – 5:30 | | 11:00 – 11:30 | | 5:00 – 5:30 | | 11:00 – 11:30 | |
| 5:30 – 6:00 | | 11:30 – 12:00 | | 5:30 – 6:00 | | 11:30 – 12:00 | |

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# Comprehensive Client Information Sheet



Name

**Lifestyle Information (continued)**

31) Exactly how much money do you spend on groceries per month (provide amounts from your last two grocery bills)?

32) How often do you grocery shop (number per week)?

33) How many meals do you eat in restaurants or fast food places per week?

34) Exactly how much money do you spend on supplements per month?

35) If you have any know food allergies, please list them below.

36) Are there any other foods to which you're particularly sensitive (i.e., which cause excessive gas, bloating, stuffiness, or congestion)?

37) If you're currently using any nutritional supplements, please list them (as well as the doses you're taking) below.

38) Please provide a Three-Day Dietary Record (attached). Be sure that these records are representative of the last few months of your dietary intake. In other words, if you just decided to get in shape 2 weeks ago and changed your diet dramatically, you should give us an indication of how you had been eating habitually prior to the recent change.

39) How long have you been eating in the manner recorded on your dietary record?
(If your answer is less than 1 month, please fill out your record according to your prior intake before this recent month.)

**Miscellaneous Information**

40) If there is any other information you think relevant to your program design, please share it with us below.

41) Please share your most frequent health, nutrition, or physique complaints and/or dissatisfaction with us.

You have now completed our client information sheet. Please bring this, along with your current workout schedule (if applicable) and Three-Day Dietary Record, to your first appointment.

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# Three-Day Dietary Record



| Name | Date |
|---|---|

It is important that this record be both accurate and representative of your normal dietary intake. Consequently, it is essential that you do not alter your normal eating habits in any way and that you record as precisely as possible every single item that you consume (this includes water, vitamins, condiments, margarine, etc). To do so, you must follow a few simple instructions (listed below). The purpose here is to quantify your normal intake so do not alter your eating habits in any way or the resulting analysis, although accurate, will be useless because it will not be representative of your typical diet. The procedure may seem somewhat cumbersome, but remember, it is only 3 days.

## Instructions

1. Keep a pen and paper with you at all times to record your intake including food item, quantity, and notes. This is imperative as snacks are typically consumed unpredictably and, as a result, it is impossible to record them accurately unless your recording forms are nearby.
2. Use a small food scale if you have one or use standard measuring devices (e.g., measuring cups, measuring spoons) to record the quantities consumed, as accurately as possible. If you do not eat all of the item (for instance a portion of an apparently delicious hastily prepared casserole of leftovers that turned out to be not so delicious), re-measure what's left and record the difference.
3. Record combination foods separately (i.e., hot dog, bun, and condiments) and include brand names of food items (list contents of homemade items) whenever possible.
4. For packaged items, use labels to determine quantities.
5. Record 3 days that are representative of your normal intake. Therefore if your weekdays are different from your weekends, pick two weekdays and one weekend. Likewise, if your M, W, and F are different from your T and Th and all these days are different from your Sat and Sun, you should pick one day to represent each unique schedule.

**Sample Dietary Record, Day 1**

| **Food Item** (include brand name) | **Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc) | **Notes** (include ingredients and amounts of homemade items) |
|---|---|---|
| *Breakfast* | | |
| *2 pieces toast* | *2 pcs* | |
| *Margarine* | *1 t* | |
| *Orange Juice* | *6 oz* | |
| *Lunch* | | |
| *Small pizza* | *400 g* | *pepperoni, mushroom, cheese* |
| *Dinner* | | |
| *Chicken* | *6 oz* | |
| *Baked Potato* | *6 oz* | |
| *Mixed Vegetables* | *1 c* | *peas, carrots, corn* |

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# Three-Day Dietary Record



| Name | Date |
|---|---|

**Dietary Record, Day 1**

| **Food Item** (include brand name) | **Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc) | **Notes** (include ingredients and amounts of homemade items) |
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# Three-Day Dietary Record



| Name | Date |
|---|---|

**Dietary Record, Day 2**

| **Food Item** (include brand name) | **Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc) | **Notes** (include ingredients and amounts of homemade items) |
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# Three-Day Dietary Record



| Name | Date |
|---|---|

**Dietary Record, Day 3**

| **Food Item** (include brand name) | **Quantity** (g, ml, tablespoons [T], teaspoons [t], cups [c], etc) | **Notes** (include ingredients and amounts of homemade items) |
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# Readiness for Change Questionnaire



One of the most important things you can do to change your lifestyle for the better is this: understand your readiness for change. In other words, although you might *want* to be in great shape, there's a difference between wanting it and being ready to do the work necessary to accomplish it. In this questionnaire we'll find out if you're really ready to make the changes necessary to improve your body composition, health, and physical performance.

Simply answer the questions to follow by selecting the response most appropriate to your situation. Once you've completed all the questions, your score will be calculated. And remember, be honest. You're doing this exercise to find out if you're really ready to make a lifestyle change. So, don't lie to yourself.

| **Questions** | **Responses and Scoring** |
|---|---|
| 1. Do you look in the mirror and get frustrated, upset, or humiliated because of how your body looks? | a) Yes (+3)<br>b) I'm Not Sure (0)<br>c) No (–3) |
| 2. When you feel run down and tired, do you blame these feelings on "getting older" or do you blame them on your lifestyle habits? | a) I blame it on getting older (–1)<br>b) I blame it on my lifestyle choices (+3)<br>c) I blame it on something else altogether (–3) |
| 3. Are you taking any medications for heart disease, high blood pressure, or type II diabetes that you didn't have to take when you were younger? | a) Yes, I'm on a number of these medications (+3)<br>b) Yes, I'm on only one of these medications (+1)<br>c) No, I'm not on any of these medications (–3) |
| 4. How do you explain the fact that you're in worse shape than when you were younger but haven't changed your habits at all? | a) I think it's my family history (–1)<br>b) I think it's that I'm less active (+3)<br>c) I think it's a natural consequence of aging (–1)<br>d) I don't know why it's happening (0) |
| 5. If you don't have anyone to exercise with regularly, are you willing to look for a physical activity partner? | a) Yes (+5)<br>b) No (–5) |
| 6. Are you willing to join a gym today? | a) Yes (+3)<br>b) No (–3) |
| 7. If someone told you that you'd need to throw away all the foods in your cupboards today and go shopping for different foods, foods more appropriate to your goal, would you do it? | a) Yes (+5)<br>b) No (–5) |
| 8. If an expert presents some information on diet and exercise that contradicts what you currently believe, what approach will you take? | a) Keep an open mind and give it a try (+3)<br>b) Ask a friend (0)<br>c) Ignore the advice (–3) |
| 9. Are you willing to have a meeting with your friends and loved ones and share with them your behavior goals and desired outcomes? | a) Yes, right away (+5)<br>b) Yes, but not just yet (–3)<br>c) No (–5) |

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# Readiness for Change Questionnaire



| Questions | Responses and Scoring |
|---|---|
| 10. If your work environment presents significant barriers to you exercising and eating well, would you consider speaking to your employer about changing some of these conditions or are you willing to find new employment? | a) Yes (+5)<br>b) No (–5) |
| 11. Are you ready to spend less time with people who offer little or no social support for your goals while spending more time with those who do offer support? | a) Yes (+5)<br>b) No (–5) |
| 12. Can you accept responsibility for the way your body is today and understand that, while your old habits don't make you a bad person, they still need to be changed? | a) Yes (+5)<br>b) No (–5) |
| 13. If a friend or loved one suggests that you don't have what it takes to get into great shape because you've failed before or for some other reason, what will be your response? | a) I can do it (+2)<br>b) I know I've got to make some changes but I'll take it one day at a time (+5)<br>c) Maybe I can't do it (–5) |
| 14. Are you willing to wake up in the morning a bit earlier and stay up at night a bit later to accomplish your goals? | a) Yes (+5)<br>b) No (–5) |
| 15. Are you willing to do at least 5 hours of physical activity each week? | a) Yes (+5)<br>b) No (–5) |

**Your score and what it means:**

**21 to 63**
It's clear that changing the way you look, feel, and perform have become very important to you and you realize that the way you're doing things right now simply isn't cutting it. You're tired of not getting results, you're tired of the growing waistline, the sluggish metabolism, of feeling that you have low energy. And not only are you tired of it, you're committed to doing something about it—today. Congratulations! Getting to this point takes a lot of work. Now, let's do something about it.

**–20 to +20**
If you scored in this range, it's important for you to stop thinking and start doing. In your mind, you're frustrated with the way things are but you're afraid that a commitment to changing the way you do things will cause you more hassle and difficulty than just sitting back, doing nothing, and continuing to look and feel the way you do today. In fact, you're not alone. This is the greatest fear of most people—that a new exercise and nutrition program will cause more pain than the pain they feel right now. If this is you it's important to step outside of your shell and seek out some people who are exercising, eating well, getting results, and having fun doing it. Clearly, millions of people out there are following a healthy lifestyle and loving every minute of it. But don't make the mistake of thinking that they never had difficulties to overcome like you do. At some point in time each and every one of them had some old set of unproductive habits to discard. Once this was accomplished, they could easily get into the zone. And you can, too. What are you waiting for?

**–61 to –21**
From the results of your questionnaire, it doesn't look like you really want to change. Is this true? Are you simply toying with the idea of getting your physical activity habits and eating habits in line with what you know they should be? Because if you are, you're not really ready to make a change. With each passing year that you avoid good activity and nutrition habits your risk for disease increases. And not only that, you'll progressively gain fat, lose muscle, and look much older than your actual age. These are the consequences of remaining indifferent to the meds you're on, the weight you've gained, and the environment you've surrounded yourself with. Are you ready to deal with them? Don't stay indifferent any longer. Take an honest look at how you've changed (on the inside and out) and admit that you could use a tune-up.

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# Kitchen Makeover Questionnaire



There's a fundamental law of human nutrition that goes like this: if a food is in your possession or located in your residence, you will eventually eat it. (Whether you plan to or not, whether you want to or not, you'll eventually eat it!) Therefore, according to this important law of human nutrition, if you wish to be healthy and lean, you must remove all foods that aren't part of your healthy eating program and replace them with a variety of better, healthier choices.

So how do you know which foods have got to go and which foods can stay? Simply answer the questions to follow by selecting the response most appropriate to your situation. Once you've completed all the questions, your score will be calculated. And remember, be honest. You're doing this exercise to find out whether or not your kitchen is in good shape.

| **Questions** | **Responses and Scoring** |
|---|---|
| 1. Do you have the following items in your kitchen?<br>* Good set of pots and pans<br>* Good set of knives<br>* Spatula<br>* Blender<br>* Tea kettle<br>* Scale for weighing foods<br>* Sealable containers for carrying meals<br>* Small cooler for taking meals to work<br>* Shaker bottle for drinks and shakes<br>* Food processor | a) I have all of them. (–5)<br>b) I have more than half of them. (–2)<br>c) I have less than half of them. (+2)<br>d) I don't have any of them. (+5) |
| 2. Do you have the following items in your pantry?<br>* Whole oats<br>* Quinoa<br>* Whole grain pasta<br>* Natural peanut butter<br>* Mixed nuts<br>* Canned or bagged beans<br>* Extra virgin olive oil<br>* Vinegar<br>* Green tea<br>* Protein supplements<br>* Fish oil supplements<br>* Green foods supplements | a) I have all of them. (–5)<br>b) I have more than half of them. (–2)<br>c) I have less than half of them. (+2)<br>d) I don't have any of them. (+5) |
| 3. Do you have the following items in your fridge or freezer?<br>* Extra-lean beef<br>* Chicken breasts<br>* Salmon<br>* Omega 3 eggs<br>* Packaged egg whites<br>* Real cheese<br>* At least four varieties of fruit<br>* At least five varieties of vegetables<br>* Flax seed oil<br>* Water filter<br>* Sweet potatoes | a) I have all of them. (–5)<br>b) I have more than half of them. (–2)<br>c) I have less than half of them. (+2)<br>d) I don't have any of them. (+5) |
| 4. Do you have the following items in your pantry?<br>* Potato or corn chips<br>* Fruit or granola bars<br>* Regular or low-fat cookies<br>* Regular peanut butter<br>* Chocolates or candy<br>* Soft drinks<br>* Crackers<br>* At least 4 types of alcohol<br>* Instant foods like cake mixes and mashed potatoes<br>* Bread crumbs, croutons, and other dried bread products | a) I have all of them. (+5)<br>b) I have more than half of them. (+2)<br>c) I have less than half of them. (–2)<br>d) I don't have any of them. (–5) |
| 5. Do you have the following items in your fridge or freezer?<br>* At least 4 types of sauces<br>* Juicy steaks or sausage<br>* At least 2 types of breads or bagels<br>* Take-out or restaurant leftovers<br>* Big bowl of mashed potatoes or pasta<br>* Margarine<br>* Fruit Juice<br>* Soft drinks<br>* Baked goods<br>* Frozen dinners | a) I have all of them. (+5)<br>b) I have half or more than half of them. (+2)<br>c) I have less than half of them. (–2)<br>d) I don't have any of them. (–5) |
| 6. Do you have bowls of candy, chips, crackers, or other snacks sitting around at home? | a) Yes (+5)<br>b) No (–5) |

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# Kitchen Makeover Questionnaire



| Questions | Responses and Scoring |
|---|---|
| 7. When you have parties or dinner guests, do you serve them what you think they'll want or what you think is healthy? | a) What I think is healthy (–3)<br>b) What I think they want (+3) |
| 8. When food shopping, do you buy economy-sized bags, or do you buy smaller portions? | a) More than half of the time I buy economy-sized bags. (+3)<br>b) More than half of the time I buy smaller portions. (–3) |
| 9. How often do you shop for groceries? | a) Fewer than 3 times a month (+5)<br>b) About once a week (–1)<br>c) More than once a week (–5) |
| 10. Do you keep food in plain view around the house? | a) Yes (+3)<br>b) No (–3) |
| 11. Do you think healthy eating means low-fat eating? | a) Yes (+2)<br>b) No (–2) |
| 12. If someone were to point to a food in your kitchen, would you know whether it was composed of mostly carbohydrate, protein, or fat? | a) Yes (–2)<br>b) No (+2) |
| 13. When you prepare meals from recipe books, do you use those that contain healthy recipes? | a) Most of the time (–5)<br>b) About half of the time (0)<br>c) Almost never (+5) |
| 14. Do you prepare meals in advance to take with you to work, on day trips, or on vacations? | a) Yes, always (–5)<br>b) More than half the time (–2)<br>c) Less than half the time (+2)<br>d) Almost never (+5) |
| 15. Are you hesitant to throw out unhealthy leftovers or gift foods that don't fit into your nutritional plan? | a) Yes, I hate throwing food out (+5)<br>b) No, more than half the time I throw this stuff out (0)<br>c) No, I always throw this stuff out (–5) |

**Your score and what it means:**

**32 to 63 points**
You've scored high on the Kitchen Makeover Questionnaire. But this high score means you're not doing so well in the kitchen department. In fact, if your kitchen stays in this condition you'll have better luck winning the lottery than getting great body composition, health, and performance results. Since you're in need of an Extreme Makeover: The Kitchen Edition, here's what to do:

Step 1: Go grab an extra-large shopping bag.
Step 2: Without thinking about it, open that bag up and with your forearm, sweep every offensive food item from your fridge, freezer, and cupboards right in. These include all items from questions 4 and 5.
Step 3: Wave goodbye as this food rolls away on the back of a garbage truck.
Step 4: Get to the grocery store immediately, and pick up the foods listed in questions 2 and 3.

**0 to 31 points**
Your kitchen's not the worst, but could certainly use some improvement. Make sure you've got all the items listed in questions 1 through 3 and fewer of the items from questions 4 and 5. Also, be sure to begin shopping more frequently, eating fresher items, and being more aware of the foods that you're eating and when. Only then will you be equipped for success.

**–31 to –1 points**
Nice job; you're doing pretty well in the kitchen department. In fact, with a few minor tweaks, your kitchen will be 100% ready to go. Review this questionnaire to figure out exactly what it'll take to get closer to a perfect score of –63.

**–32 to –63 points**
Don't let the negative scores fool you, negative scores on the Kitchen Makeover Questionnaire mean that you don't need much of a makeover. And that's great! So congratulations on your great kitchen set-up. With your kitchen full of these great foods (like those listed in questions 2 and 3) and the right appliances, you'll be the envy of all your fitness and nutrition conscious friends.

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# Social Support Questionnaire



Social support is defined as having a network of people that support your endeavors, contribute positively to your decision-making processes, and are there for you when you need help. Scientists have suggested that people with this kind of network around them can transcend even the worst environments and accomplish great things. Unfortunately, people who don't have this type of network have a harder time accomplishing even modest goals. Remember this: who you are today and who you become in the future has a lot to do with who you choose to spend your time with.

The following questions are designed to assess your level of social support. Since this variable is a very important determinant of how well you'll do following any nutrition or exercise program, let's figure out, right now, how much social support you've got around you. Simply answer the questions to follow by selecting the response most appropriate to your situation. Once you've completed all the questions, your score will be calculated. And remember, be honest. You're doing this exercise to find the areas of your life that might present challenges to your progress. But be careful, once you recognize your challenges it's easy to blame them for your outcomes. Don't do this. You're in control. You have the power to place yourself in the right environment so use it!

| **Questions** | **Responses and Scoring** |
|---|---|
| 1. Do the people you spend each day with (at work or at home) follow healthy lifestyle habits such as exercising regularly, watching what they eat, and taking nutritional supplements? | a) Yes, most of them do. (3)<br>b) About half do and half don't. (0)<br>c) No, Most of them don't. (–3) |
| 2. Does your spouse or partner follow healthy lifestyle habits such as exercising regularly, watching what he/she eats, and taking nutritional supplements? | a) Yes, my spouse/partner does (5)<br>b) No, my spouse/partner doesn't (–5)<br>c) I don't have a spouse or partner (0) |
| 3. When you want to perform some physical activity such as going for a workout or taking a hike, is it easy for you to find a partner to go with? | a) Yes, it's easy to find a partner. (2)<br>b) No, I don't know anyone. (0)<br>c) No, those around me don't do much physical activity. (–2) |
| 4. At your workplace do your coworkers regularly bring in treats like cookies, donuts, and other snacks? | a) Yes, they often do. (–4)<br>b) Yes, but very infrequently. (0)<br>c) No, they never do. (+4) |
| 5. If you go out to eat more than once per week, do the people you dine with order healthy selections? | a) Yes, they always do. (+2)<br>b) Only about half of the time. (0)<br>c) No, they never do. (–2) |
| 6. Do you belong to any clubs, groups, or teams that meet at least 2X per week and do some physical exercise (this does not include a health club membership)? | a) Yes, I've been a member for years (+5)<br>b) Yes, I've just started (+2)<br>c) No, I don't (0) |
| 7. Do you belong to a health club and attend, on average, at least 3 times per week? | a) Yes, I've been doing this for at least 1 year. (+2)<br>b) Yes, I've just joined. (+1)<br>c) No, I don't. (0) |
| 8. When discussing your nutrition and exercise goals with friends, do they seem interested in getting on board, or do they think you're crazy? | a) They're very interested. (+2)<br>b) They're not interested. (0)<br>c) They think I'm crazy. (–2) |
| 9. Do the people you live with bring home foods that aren't considered healthy or good for you? | a) Always (–5)<br>b) Sometimes (–3)<br>c) Never (0) |

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# Social Support Questionnaire



| Questions | Responses and Scoring |
|---|---|
| 10. Do the people you live with bring home foods that are considered healthy or good for you? | a) Always (+5)<br>b) Sometimes (0)<br>c) Never (–5) |
| 11. Do the people you live with or work with schedule activities for you that interfere with your preestablished exercise time? | a) Always; they don't respect my time. (–3)<br>b) Sometimes; they don't think about it. (-1)<br>c) Never; they respect this time. (3) |
| 12. Do those around you bring nutrition, exercise, or supplement information to your attention so that you can stay informed about these topics? | a) Always (+5)<br>b) Sometimes (+2)<br>c) Never (0) |

**Your score and what it means:**

**20 to 38 total points**
You've got a great support network around you. Of course, that's not all you'll need to succeed with a good nutrition and exercise program, but it's a great start. And even thought you may have scored relatively high on this questionnaire, be sure to do your best to support those around you. Social support works both ways: in order to make sure you keep this great group of people around you, you'll have to offer support to them as well.

**5 to 19 total points**
It looks like you've got some social support around you but there are obviously a few areas of your life that will present challenges. Be sure to look around you and be aware of workplace challenges, at-home challenges, and relationship challenges that might stand in your way. Make sure to inventory the items in this questionnaire and come up with creative ways to improve the social environment around you.

**4 to –14 total points**
Your social support is lacking and needs a makeover. While some of your environment isn't conducive to your goals, there are some areas that you can latch on to. Your first step is to figure out which areas are lacking and take steps to fix them. Join a health club, dine with friends committed to health, spend time doing nonfood-related things with your other friends, and avoid the donut tray at work. And remember, although it's easy to blame those around you for not being as supportive as you'd like, choosing new exercise and nutrition goals is your own choice, not necessarily theirs. Instead of blaming them, simply come up with creative and nonantagonistic ways to enlist their support.

**–15 to –31 total points**
This score is quite low and therefore signals some real problems in your work and at home environments, as well as in your relationships. Of course, some people have been known to succeed in reaching their goals by going it alone. But the ability to succeed with a "lone ranger" mentality is too difficult for most to accomplish. Therefore, without some serious changes, your environment will almost certainly cause your old habits to surface. Important changes may include: having a serious talk with your friends and family in order to express to them how important this is to you, going out immediately and joining a club or group that meets for regular exercise, or finding a workout partner that is as motivated as you are. And remember, although it's easy to blame those around you for not being as supportive as you'd like, instead of blaming them, simply come up with creative and nonantagonistic ways to enlist their support. Of course, if it comes down to it, pick some new friends. Your social group is one of the most important variables in your success.

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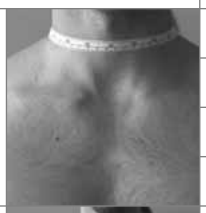
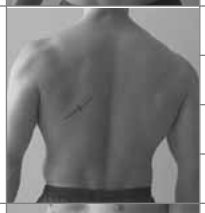
# Initial Body Composition Assessment (Men)



| Skinfolds | | | Girths | | |
|---|---|---|---|---|---|
| **Site** | | **Measurements (mm)** | **Site** | | **Measurements (cm)** |
| **Abdominal skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Neck Girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Triceps skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Shoulder girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Chest skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Chest girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Midaxillary skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Upper-arm girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Subscapular skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Waist girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Suprailiac skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Hip girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Thigh skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Thigh girth (cm)** |  | 1:<br>2:<br>3:<br>Mean:: |
| **Sum of mean skinfolds (mm) =** | | | **Calf girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Body fat % (See appendix A for calculations) =** | | | | | |

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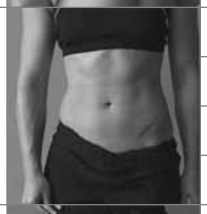
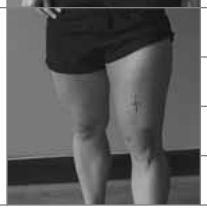
# Initial Body Composition Assessment (Women)



| **Skinfolds** | | | **Girths** | | |
|---|---|---|---|---|---|
| **Site** | | **Measurements (mm)** | **Site** | | **Measurements (cm)** |
| **Abdominal skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Neck Girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Triceps skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Shoulder girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Chest skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Chest girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Midaxillary skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Upper-arm girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Subscapular skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Waist girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Suprailiac skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Hip girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Thigh skinfold (mm)** |  | 1:<br>2:<br>3:<br>Mean: | **Thigh girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Sum of mean skinfolds (mm) =** | | | **Calf girth (cm)** |  | 1:<br>2:<br>3:<br>Mean: |
| **Body fat % (See appendix A for calculations) =** | | | | | |

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# Initial Recovery Assessment



Rate the following mood qualities on a scale of 0 to 5 as follows:

Appetite: 0=No Appetite 5=Very hungry

Sleep quality: 0=Poor sleep 5=Very good sleep

Tiredness: 0=No tiredness 5=Very tired

Willingness to train: 0=No willingness 5=Very excited to train

| **Mood quality** | **Rating (0–5)** |
|---|---|
| Appetite | |
| Sleep quality | |
| Tiredness | |
| Willingness to train | |

Record your resting heart rate (taken first thing in the morning while seated, not standing) below. Place your index and middle finger on either your carotid artery (neck) or your radial artery (inside of your wrist) and count the number of beats you feel in 60 seconds.

| **Resting morning heart rate (beats/minute)** | |
|---|---|

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# Initial Performance Assessment



## Maximal Strength

| Major lift | Repetitions | Load |
|---|---|---|
| Bench press | 1RM or 3RM | |
| Squat | 1RM or 3RM | |
| Deadlift | 1RM or 3RM | |

## Power

| Power test | Repetitions | Load |
|---|---|---|
| Barbell clean | 1RM | |
| Barbell snatch | 1RM | |
| **Power test** | **Repetitions** | **Height/Distance** |
| Vertical jump | 1 jump | |
| Overhead medicine ball toss | 1 toss | |

## Strength

| Major lift | Max | % of Max | Load | Repetitions |
|---|---|---|---|---|
| Bench press | | | | |
| Squat | | | | |
| Deadlift | | | | |

## Endurance

| Test | Speed | Elevation |
|---|---|---|
| Vmax | | |
| **Test** | **Time at Vmax** | |
| Tmax | | |

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# Blood Chemistry Assessment



| Name | Date |
|---|---|

Below is a list of recommended blood chemistry assessments. Bring this list to your phyisician and inquire about having these tests done.

| **General tests** | **Cardiovascular risk profile** | **Hormones** |
|---|---|---|
| Typically called SMAC-20, SMA-20, or Chem-20, this basic test looks at 20 different parts of the blood including blood levels of certain minerals, proteins, etc. | Total cholesterol | Testosterone |
| | LDL | Free testosterone |
| | HDL | IGF-1 |
| | Triglycerides | Growth hormone |
| | C-reactive protein | DHEA/DHEAs |
| | Homocysteine | Estradiol |
| | **Prostate tests (for men)** | **Carbohydrate tolerance** |
| | PSA | Fasted insulin |
| | | Fasted glucose |
| **Liver function tests** | **Kidney function tests** | **Thyroid panel** |
| Alkaline phosphatase | Creatinine | TSH |
| GGT | BUN | T3 |
| SGOT | Creatinine/BUN ratio | T4 |
| SGPT | | rT3 |
| Bilirubin | | |

| Physician name: | Date of consult: |
|---|---|
| Physician notes: | |

# the Five Habits Cheat Sheet

Here are some questions to help keep your eating habits on the right track. If your answers don't correspond with those provided below then adjust your habits accordingly. Ready...set...eat right!

## When did you last eat?

If it's been longer than 2-4 hours, it's time to eat.


## Where is the complete protein?

Are you about to eat at least 1 serving (20-30 g) of complete protein? If not, find some protein.

Women get 1 serving and men get 2.

## Where are the veggies?

Are you about to eat at least 2 servings of veggies? Prepare them anyway you like, but eat them with every meal or snack.

(One serving is about 1/2-1 cup and your target is 5-10 cups per day).

## Where are the carbs?

If you have fat to lose but haven't just worked out, put down the pasta, bread, rice, and other starchy carbs in favor of a double serving of fruits and veggies. If you have just worked out, a mix of carb sources is fine.

## Where are your fats coming from?

Today you need some fat from animal foods, from olive oil, from mixed nuts, and from flaxseeds/ flaxseed oil. Spread them throughout the day but make sure to add them in.

*International Sports Sciences Association*


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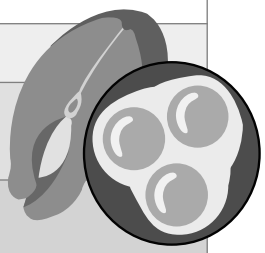
## Protein Chart

| | |
|---|---|
| **Type** | Lean, complete protein sources |
| **Timing** | Eaten with each feeding opportunity |
| **Amount** | 1 serving for women (size of palm)<br>2 servings for men (size of two palms) |
| **Examples** | Lean meats (ground beef, chicken, turkey, bison, venison, etc.)<br>Fish (salmon, tuna, cod, roughy)<br>Eggs (egg whites, occasional whole eggs)<br>Low fat dairy (cottage cheese, yogurt, part skim cheese, string cheese, etc.)<br>Vegetarian choices (tofu, tempeh, soy burgers, soy jerkey, soy sausage, soy bacon, seitan, etc.)<br>Milk protein supplements (whey, casein, milk protein blends) |



## Carb Chart

| Type | Exercise recovery drink | Simple sugars and highly processed starches | Whole-grain and starchy carbohydrates | Fruits and vegetables |
|---|---|---|---|---|
| **Timing for Fat Loss** | During exercise only* | Minimize intake | Eat soon (within 1-2 hours) after exercise | Eaten with each feeding (with emphasis on veggies) |
| **Timing for Muscle Gain** | During and after exercise | Immediately after exercise (if at all)** | Eat soon (within 3 hours) after exercise*** | Eaten with each feeding |
| **Examples** | Sugary, protein-rich recovery drinks *(Biotest Surge, Endurox R4 etc.)* | Sugary sports drinks<br>Breakfast cereals<br>Soda<br>Fruit juice<br>Table sugar<br>Sugary desserts<br>Ice cream<br>Muffins, bagels, and other carb-rich snacks | Bread *(whole grain)*<br>Pasta *(whole grain or flax)*<br>Rice *(whole grain, unprocessed)*<br>Potatoes *(sweet potatoes or yams)*<br>Oats *(preferably whole oats)*<br>Cereal Grains *(wheat, rye, etc.)* | Spinach<br>Carrots<br>Tomatoes<br>Broccoli<br>Cauliflower<br>Apples<br>Oranges<br>Avocados<br>Berries |

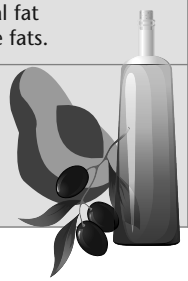
* If you tolerate carbs well, you can include such a drink during exercise. If you don't you should probably stick with water or a branched-chain amino acid workout drink.

** These food choices should be minimized yet are permissible after exercise for those with good carbohydrate tolerance and the goal of weight gain.

*** These foods can be included throughout the day for those with good carbohydrate tolerance who are having a hard time gaining weight.

## Fat Chart

| Type | Saturated fat | Monounsaturated fat | Polyunsaturated fat |
|---|---|---|---|
| **Timing** | None, just be sure to get about 1/3 of total fat intake from these fats. | None, just be sure to get about 1/3 of total fat intake from these fats. | None, just be sure to get about 1/3 of total fat intake from these fats (focusing on the omega-3 fats). |
| **Examples** | Animal Fats *(fat in eggs, dairy, meats, butter, cheeses, etc.)*<br>Coconut Oil<br>Palm Oil | Olive oil<br>Nuts<br>Nut butters<br>Avocado | Flax Seeds/Oil<br>Fish Oil<br>Nuts and Nut Butters<br>Vegetable Oils |



# the 21 Superfoods

Here is a list of tasty, nutrient-packed "superfoods" to help you make good decisions when fueling your body. Use the Superfoods Checklist to track how many Superfoods you select every week.

## Protein

1. Lean red meat (93% lean, top round, sirloin)
2. Salmon
3. Omega-3 eggs
4. Low-fat, plain yogurt (lactose-free if you can find it)
5. Protein supplements (milk protein isolates, whey protein isolates, or rice protein isolates)

## Veggies and Fruits

6. Spinach
7. Tomatoes
8. Cruciferous vegetables (broccoli, cabbage, cauliflower)
9. Mixed berries
10. Oranges

## Other Carbs

11. Mixed beans
12. Quinoa
13. Whole oats

## Good Fats

14. Mixed nuts
15. Avocados
16. Extra virgin olive oil
17. Fish Oil
18. Flax seeds (ground)

## Drinks/Other


19. Green tea
20. Liquid exercise drinks (quickly digested carbohydrate and protein)
21. Greens+ (vegetable concentrate supplement)

**Do not select foods that you are allergic to or intolerant of.**

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| Superfoods Checklist | Subcategory | Weekly servings | | | | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 |
| **Protein Foods** | | | | | | |
| Lean Red Meat *(93% lean, top round, sirloin)* | Protein - Lean meat | | | | | |
| Salmon | Protein - Fish | | | | | |
| Omega 3 Eggs | Protein - Dairy | | | | | |
| Low-fat, Plain Yogurt *(lactose-free if you can find it)* | Protein - Dairy | | | | | |
| Supplemental Protein *(milk protein isolates, whey protein isolates, or rice protein isolates)* | Protein - Powder | | | | | |
| **Carbohydrate Foods** | | | | | | |
| Spinach | Carb - Vegetable | | | | | |
| Tomatoes | Carb - Vegetable | | | | | |
| Cruciferous Vegetables *(broccoli, cabbage, cauliflower)* | Carb - Vegetable | | | | | |
| Mixed Berries *(strawberries, blueberries, raspberries, etc.)* | Carb - Fruit | | | | | |
| Oranges | Carb - Fruit | | | | | |
| Mixed Beans *(kidney, navy, white, etc.)* | Carb - Legume | | | | | |
| Quinoa | Carb - Grain | | | | | |
| Whole Oats *(large flake)* | Carb - Cereal | | | | | |
| **Fat Foods** | | | | | | |
| Mixed Nuts *(a variety of different types of nuts including pecans, walnuts, cashews, brazil nuts, etc.)* | Fat - Seeds and nuts | | | | | |
| Avocados | Fat - Fruit | | | | | |
| Olive Oil *(extra virgin)* | Fat - Oils | | | | | |
| Fish Oil *(salmon, anchovy, menhaden, krill)* | Fat - Oils | | | | | |
| Flax Seeds *(ground)* | Fat - Seeds and nuts | | | | | |
| **Liquid Drinks** | | | | | | |
| Green Tea | Teas | | | | | |
| Liquid Exercise Drinks *(quickly digested carbohydrate and protein)* | Recovery drinks | | | | | |

## Do not select foods that you are allergic to or intolerant of.

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# Limiting Factors and Behavior Goals (trainer's log)



Client

| Date | Limiting Factor | Behavior Goal |
|---|---|---|
| | | |
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# Biweekly Adherence Chart

Name:

Date:

- Place an **X** in the box each time you eat a compliant meal.
- Place a **0** in the box each time you miss a meal.
- Place a ***** in the box each time you eat a noncompliant meal.
- Place **N/A** in the box if a meal is not applicable.

x = compliant

0 = missed

* = noncompliant

N/A = not applicable

| Week ___ Adherence | **Meal 1** | **Meal 2** | **Meal 3** | **Meal 4** | **Meal 5** | **Meal 6** | **(Workout drink)** |
|---|---|---|---|---|---|---|---|
| Day 1 | | | | | | | |
| Day 2 | | | | | | | |
| Day 3 | | | | | | | |
| Day 4 | | | | | | | |
| Day 5 | | | | | | | |
| Day 6 | | | | | | | |
| Day 7 | | | | | | | |
| Day 8 | | | | | | | |
| Day 9 | | | | | | | |
| Day 10 | | | | | | | |
| Day 11 | | | | | | | |
| Day 12 | | | | | | | |
| Day 13 | | | | | | | |
| Day 14 | | | | | | | |

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# Biweekly Client Report



**Instructions**
This is your biweekly body composition, physical alteration, and recovery questionnaire. In order to provide the best possible service, it is important that you fill out all the information below. This means keeping a daily record of body weight and of the recovery measures. Please bring this report to your next check-in meeting. Also note that your skinfold measures and girths will be collected during this meeting, so you can leave those sections blank.

**Disclaimer**
Please recognize the fact that it is your responsibility to work directly with your physician before, during, and after seeking fitness consultation. As such, any information provided is not to be followed without the prior approval of your physician. If you choose to use this information without the prior consent of your physician, you are agreeing to accept full responsibility for your decision.

**Basic Information**

| 1. Name | | | | | 2. Date | | |
|---|---|---|---|---|---|---|---|

3. Body Weight (in lb)

| Day | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Week #1 | | | | | | | |
| Week #2 | | | | | | | |

4. What is your body fat percentage (have this taken before submitting this sheet)?

| 5. Please provide the following skinfold measures (mm)*. | | | | 6. Please provide the following girth measurements (in or cm)*. | | | |
|---|---|---|---|---|---|---|---|
| Abs | | Subscapular | | Neck | | Chest | |
| Triceps | | Suprailiac | | Shoulder | | Waist | |
| Chest | | Thigh | | Biceps | | Thigh | |
| Mid-axillary | | | | Calf | | | |

*Note: These will be collected and recorded during your next appointment.

7. To ensure that your goals and our approach are still on the same track, please reevaluate and rank your goals at this current time (rank these goals according to importance with 1 being the most important and 8 being the least).

| | | | |
|---|---|---|---|
| Improved health | Increased muscle mass | Improved endurance | Lose fat |
| Increased strength | Increased power | Sport specific** | Gain weight |

**If "sport specific" was selected, please provide the sport/athletic event you are training for:

8. Is there a specific timeline for achieving your specific goals?

9. What's of greater importance: (check one)

❒ Immediate progress that's less easily maintained ❒ Maintainable progress that may not be as rapid

Please explain: _____

_____

_____

_____

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# Biweekly Client Report



## Subjective Recovery Measures

10. Please rate (daily) each of the following variables on a scale of 0 – 5 as follows:

Appetite (A): 0=No Appetite; 5=Very Hungry

Sleep Quality (SQ): 0=Poor Sleep; 5=Very Good Sleep

Tiredness (T): 0=No Tiredness; 5=Very Tired

Willingness to Train (WtT): 0=No willingness; 5=Very excited to train

| Day | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | | Sunday | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Week #1 | A | | A | | A | | A | | A | | A | | A | |
| | SQ | | SQ | | SQ | | SQ | | SQ | | SQ | | SQ | |
| | T | | T | | T | | T | | T | | T | | T | |
| | WtT | | WtT | | WtT | | WtT | | WtT | | WtT | | WtT | |
| Week #2 | A | | A | | A | | A | | A | | A | | A | |
| | SQ | | SQ | | SQ | | SQ | | SQ | | SQ | | SQ | |
| | T | | T | | T | | T | | T | | T | | T | |
| | WtT | | WtT | | WtT | | WtT | | WtT | | WtT | | WtT | |

## Objective Recovery Measure

11. Please record your morning resting pulse for each day. This is to be taken seated, immediately upon waking. Take your radial pulse (wrist) for 15 seconds and multiply by 4 to get a minute value. Record this minute value (beats per minute) here:

| Day | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | | Sunday | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Week #1 | | | | | | | | | | | | | | |
| Week #2 | | | | | | | | | | | | | | |

## Perceived Appearance

12. Below, please give us a general idea of your perception of improvement. Are you getting tighter, more muscular, or more vascular? Let us know what changes you see when looking into the mirror. Please describe them in your own words.

## Gym Performance

13. Subjective appraisal: Below, please give us a general idea of how your workouts are going. Are you getting stronger, more powerful, or improving your anaerobic tolerance? Let us know what changes you feel when working out. Please describe them in your own words. You can also use this section to highlight "problems" or concerns you are having relative to the workout.

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# Biweekly Client Report



**Nutritional Comments**

14. Below, please give us a general idea of how your nutritional program is going. Are you having difficulty following it or is it easy to eat this way? Let us know how successful you've been with respect to avoiding unhealthy choices and making more positive eating decisions.

**Adherence to Nutrition Plan**

15. Please place an "X" only in squares corresponding to the day and meal where you followed the nutrition plan, as outlined 100%. Please input a "N/A" in boxes that don't apply to you (example: if you are only required to eat 5 meals per day, place n/a in the 6, 7 and 8 columns). Finally, the order of your meals isn't important. So as long as you've managed to get the meal in it counts as 100% adherence for that meal (for instance if you ended up switching meals 1 and 5 around to better fit your schedule, you'd still place an X for each meal).

| | Daily meals | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Days | 1 | | | | | | | | |
| | 2 | | | | | | | | |
| | 3 | | | | | | | | |
| | 4 | | | | | | | | |
| | 5 | | | | | | | | |
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| | 12 | | | | | | | | |
| | 13 | | | | | | | | |
| | 14 | | | | | | | | |

16. Are there adherence problems you'd like to elaborate on specifically or does it seem easy?

17. With an increase in protein intake, some people may experience abdominal bloating, gas, or constipation. Are you experiencing any negative gastrointestinal symptoms? Please describe.

18. How much are you now spending on groceries per week (please list grocery bill totals for both weeks)?

19. How much money are you now spending on supplements per month (total for the month)?

20. How often have you been eating out in restaurants per week?

21. Have any of your previous health, nutrition, or physique complaints decreased?

22. Below, please provide any general comments not covered above that you think we should or would like to know. Positive and negative feedback is welcome.

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# Follow-up Performance Assessment



| Name | Date |
|---|---|
| | |

## Maximal Strength

| **Major lift** | **Reps** | **Initial testing load** | **Month 1:** checkup load | **Month 2:** checkup load | **Month 3:** checkup load |
|---|---|---|---|---|---|
| Bench press | | | | | |
| Squat | | | | | |
| Deadlift | | | | | |

## Power

| **Power test** | **Reps** | **Initial testing load** | **Month 1:** checkup load | **Month 2:** checkup load | **Month 3:** checkup load |
|---|---|---|---|---|---|
| Barbell clean | 1RM | | | | |
| Barbell snatch | 1RM | | | | |
| **Power test** | **Reps** | **Initial height/distance** | **Month 1:** checkup height/distance | **Month 2:** checkup height/distance | **Month 3:** checkup height/distance |
| Vertical jump | 1 jump | | | | |
| Overhead medicine ball toss | 1 toss | | | | |

## Strength

| **Major lift** | **1RM load** | **% of Max** | **Load** | **Initial load** | **Month 1:** checkup repetitions | **Month 2:** checkup repetitions | **Month 3:** checkup repetitions |
|---|---|---|---|---|---|---|---|
| Bench press | | | | | | | |
| Squat | | | | | | | |
| Deadlift | | | | | | | |

## Endurance

| **Test** | **Initial Speed** | **Final Elevation** | **Month 1:** checkup elevation | **Month 2:** checkup elevation | **Month 3:** checkup elevation |
|---|---|---|---|---|---|
| Vmax | | | | | |
| **Test** | **Initial time** at initial Vmax | | **Month 1:** checkup time at initial Vmax | **Month 2:** checkup time at initial Vmax | **Month 3:** checkup time at initial Vmax |
| Tmax | | | | | |
| **Test** | **New Vmax** | | **Month 1:** checkup time at new Vmax | **Month 2:** checkup time at new Vmax | **Month 3:** checkup time at new Vmax |
| Tmax | | | | | |