

Athlete Questionnaire

CONTACT INFORMATION

Name: _____ Date of Birth: ____ / ____ / ____ Age: _____

Height: _____ Weight: _____ Gender: male female

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ - _____ - _____ cell home work

Email: _____ @ _____

What are the best times to reach you? _____

How did you hear about Integrative Multisport? _____

What services are you interested in? _____

When would you like to start your training? _____

TRAINING FACTORS

How many hours per week do you have to train? _____

What day typically works best for long workouts? _____

What day typically works best as a day off? _____

How stressful is your job (5 = high, 3 = average, 1 = low)? _____

Are there any other criteria that may affect training or training time? _____

PERSONAL INFORMATION (optional)

Occupation: _____ Hours per week: _____

Relationship status: _____ Children: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ - _____ - _____ cell home work

MEDICAL HISTORY

- 1. yes no Have you ever had a heart attack, heart disease, heart surgery or a heart murmur?
- 2. yes no Do you ever have chest, shoulder, neck or arm pains after exercise?
- 3. yes no Do you have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)?
- 4. yes no Do you have, or have you ever had high blood pressure (> 140/90)?
- 5. yes no Do you have, or have you ever had high cholesterol (> 200 mg/dL)?
- 6. yes no Do you have diabetes?
- 7. yes no Are you more than 20 pounds overweight?
- 8. yes no Do you, or have you ever smoked regularly?
- 9. yes no Are you currently physically inactive (i.e. you get less than 30 minutes of physical activity 3 days per week)?

Please explain any "yes" answers above:

- 10. yes no Do you have any injuries—past or present—that would be adversely affected by exercise?
- 11. yes no Have you had any surgery in the past year?
- 12. yes no Do you have, or have you ever suffered from asthma?
- 13. yes no Have you ever fainted, felt dizzy, or unusually winded after exercise?
- 14. yes no Do you have any metabolic diseases—controlled or uncontrolled—such as hyperthyroidism, diabetes, etc.?
- 15. yes no Are you, or have you ever been anorexic or bulimic?
- 16. yes no Are you currently using any medications?
- 17. yes no Are you, or have you recently been pregnant?
- 18. yes no Are you aware—through your own experience or a doctor's advice—of any physical reasons against your exercising without medical supervision?
- 19. yes no Are there any other physical or emotional issues that may affect your training?

Please explain any "yes" answers above:

ATHLETIC HISTORY AND CURRENT FITNESS LEVEL

1. What sports and activities have you participated in most often throughout your life? Include duration participated, how long ago, how competitive you were, and any other comments.

2. List your best race times (with splits if possible). Include the race name/location and date.

3. On average, how many hours per week did you train in the past year? _____

4. How does this compare to your activity level over the past several years? low normal high

5. How do you feel your current fitness level compares to your highest fitness level in the past five years? lower same higher

6. What is the longest workout you have ever done? _____

7. What is your longest workout in the past year? _____

8. What is your longest workout in the past month? _____

9. Please describe a typical training week below. Total hours for the week = _____

Mon _____

Tues _____

Wed _____

Thurs _____

Frid _____

Sat _____

Sun _____

10. Do you keep a training log? yes no

11. Do you currently do strength training? yes no

12. Do you stretch on a regular basis? yes no

13. How would you describe your nutritional habits? _____

14. Do you ever train with a group? What sports? How often? _____

15. Have you ever had an exercise related injury that has caused you to stop exercising for a week or more? If so, explain.

ABILITIES PROFILE

To help determine your strengths and limiters, please rate your abilities below with the following scale:

- 5 = among the best in my category
- 3 = about the same as others in my category
- 1 = among the worst in my category

Swim Bike Run

- ___ ___ ___ **Endurance:** ability to delay the onset and reduce the effects of fatigue (e.g. I am stronger at the end of long workouts than others in my category)
- ___ ___ ___ **Force:** ability to overcome resistance (e.g. I do well in rough water, on hills, in wind)
- ___ ___ ___ **Speed Skills:** ability to move effectively (e.g. my stride is short and quick; I have always been better at sprints than long races)
- ___ ___ ___ **Muscular Endurance:** ability of the muscles to maintain a relatively high force load for a prolonged time (e.g. I am good at tempo workouts and sustained efforts of several minutes)
- ___ ___ ___ **Anaerobic Endurance:** ability to resist fatigue at very high efforts when arm/leg turnover is rapid (e.g. the shorter the race, the better I do)
- ___ ___ ___ **Power:** ability to apply maximum force quickly (e.g. I am good at short, steep hills and/or fast swim starts)

MENTAL SKILLS PROFILE

Please rate your:

- | | | | | | |
|--------------------------|------------------------------------|-------------------------------|----------------------------------|-------------------------------|-------------------------------|
| 1. Motivation | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| 2. Confidence | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| 3. Thought habits | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| 4. Focus | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| 5. Visualization | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Average | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |

EQUIPMENT

1. Do you own any of the following?

- yes no Heart rate monitor
- yes no Bicycle computer with cadence
- yes no Power meter device
- yes no Garmin Forerunner GPS device
- yes no Bike trainer or rollers
- yes no Treadmill
- yes no Exercise ball
- yes no Stretch cords

2. Do you have access to any of the following?

- yes no Weight room
- yes no Treadmill
- yes no Track
- yes no Bike trainer or rollers

3. **Swim.** What pool(s) do you have access to? What is the length (e.g. 25 yards, 50 meters)?

4. **Bike.** What bike(s) do you ride (e.g. make/model of road, mountain, time trial bikes)? What pedal system and shoes do you use (e.g. Look road pedals)?

5. **Run.** What running shoes do you use (e.g. Nike Pegasus)?
