Physical Activity Readiness Questionnaire (PAR-Q)

Name: _____ Date: _____

A Questionnaire for People Aged 15 to 69

Regular physical activity is fun and healthy, and 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 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 to 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.

If you answered NO to all of the 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.

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?

YES	NO		YES	NO		YES	NO	
☐	☐	1. Allergies	☐	☐	11. Ulcer	☐	☐	22. Epilepsy
☐	☐	2. Loss of hearing	☐	☐	12. Heart attack	☐	☐	23. Convulsions/seizures
☐	☐	3. Asthma	☐	☐	13. Heart murmur	☐	☐	24. Stroke
☐	☐	4. Kidney disease	☐	☐	14. Positive stress test	☐	☐	25. Diabetes
☐	☐	5. Prostatitis	☐	☐	15. Heart valve abnormality	☐	☐	26. Thyroid trouble
☐	☐	6. Colitis	☐	☐	16. Angina	☐	☐	27. Anemia
☐	☐	7. Hepatitis	☐	☐	17. Heart failure	☐	☐	28. Eczema
☐	☐	8. Liver disease	☐	☐	18. High cholesterol	☐	☐	29. Cancer (including skin cancer)
☐	☐	9. Elevated liver enzyme test	☐	☐	19. High blood pressure	☐	☐	30. Sleep apnea
☐	☐	10. Pancreatitis	☐	☐	20. Arthritis/rheumatism			
			☐	☐	21. Loss of consciousness			

REVIEW OF CONDITIONS

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

EYES, EARS, NOSE, THROAT

YES	NO	
☐	☐	31 Difficulty with night vision
☐	☐	32. Change in vision
☐	☐	33. Blurred or double vision
☐	☐	34. Bleeding gums
☐	☐	35. Frequent nosebleeds
☐	☐	36. Frequent sinus trouble
☐	☐	37. Recent hoarseness
☐	☐	38. Ringing/buzzing ears
☐	☐	39. Earaches

PULMONARY

YES	NO	
☐	☐	40. Shortness of breath
☐	☐	41. Chronic or frequent cough
☐	☐	42. Brown/blood-tinged sputum
☐	☐	43. Chest tightness
☐	☐	44. Wheezing

GENITO-URINARY

YES	NO	
☐	☐	45. Bladder trouble
☐	☐	46. Blood in urine
☐	☐	47. Irregular vaginal bleeding
☐	☐	48. Currently pregnant
☐	☐	49. Difficulty starting/stopping urination
☐	☐	50. Urinating 3 times per night
☐	☐	51. Frequent or painful urination
☐	☐	52. Problems with sexual function

GASTROINTESTINAL

YES	NO	
☐	☐	53. Vomited blood
☐	☐	54. Persistent diarrhea
☐	☐	55. Persistent constipation
☐	☐	56. Frequent abdominal pain
☐	☐	57. Frequent nausea
☐	☐	58. Frequent indigestion/heartburn
☐	☐	59. Black/bloody bowel movement
☐	☐	60. Hemorrhoids
☐	☐	61. Trouble swallowing
☐	☐	62. Hernia

CENTRAL NERVOUS SYSTEM

YES	NO	
☐	☐	63. Fainting spells
☐	☐	64. Recurrent dizziness
☐	☐	65. Frequent headaches
☐	☐	66. Tremors
☐	☐	67. Memory loss
☐	☐	68. Loss of coordination
☐	☐	69. Difficulty concentrating
☐	☐	70. Numbness/tingling extremities

HEART/VASCULAR

YES	NO	
☐	☐	71. Palpitation (irregular heartbeat)
☐	☐	72. Pain or discomfort in chest
☐	☐	73. High cholesterol
☐	☐	74. Swelling of feet
☐	☐	75. Leg pain while walking
☐	☐	76. Painful varicose veins

PERSONAL MEDICAL HISTORY

MUSCULOSKELETAL		MISCELLANEOUS			
YES	NO	YES	NO	YES	NO
☐	☐ 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

ADDITIONAL HEALTH AND LIFESTYLE QUESTIONS

Please answer the following questions honestly:

YES	NO	
☐	☐	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, list what you are being treated for on the next page.
☐	☐	100. Have you had a change in the size or color of a mole, or a sore that would not heal in the past year?
☐	☐	101. Do you have any special concerns regarding your health that you would like to discuss with the doctor?
☐	☐	102. Are you a current cigarette smoker? A. How many packs of cigarettes do you smoke a day? _____ B. How long have you been smoking? _____
☐	☐	103. Are you an ex-smoker? A. How many years did you smoke? _____ B. How many packs a day? _____ C. When did you quit? _____
☐	☐	104. Have you used chewing tobacco or smoked cigars/pipe in the last 15 years?

105. I drink _____ beers; _____ ounces of hard liquor; _____ ounces of wine per week.

106. When were your most recent immunizations?

Tetanus _____ Flu shot _____ Pneumovax _____

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

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

Mammogram _____ Results? _____ Sigmoidoscopy _____ Results? _____

Pap smear _____ Results? _____

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

_____

_____

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

_____

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

☐ Low-fat ☐ Low-carb ☐ High-protein ☐ Vegetarian/Vegan ☐ No special diet

Please explain all YES answers here. List the question number, and add details.

PERSONAL MEDICAL HISTORY

QUESTION NUMBER	DETAILS

Comprehensive Client Information Sheet

Name: _____ Date: _____

INSTRUCTIONS

This is your comprehensive client information sheet, in which 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.

COMPREHENSIVE CLIENT INFORMATION SHEET

PART 1: BASIC INFORMATION

Name _____ Gender _____ Age _____

Date of birth (month/day/year) _____ _____ _____ Height _____ Weight (as of this morning) _____

Body fat percentage (have this taken before submitting this sheet) _____

PART 2: BODY COMPOSITION

Please provide the following skinfold measures (in mm):

Abdominal _____ Subscapular _____

Triceps _____ Suprailiac _____

Chest _____ Thigh _____

Mid-axillary _____

Please provide the following girth measurements (inches or centimetres).

Neck _____ Chest _____

Shoulder _____ Biceps _____

Waist _____ Hips _____

Thigh _____ Calf _____

PART 3: GOALS

Given the following goals, please rank them in order of importance, with 1 being **most important** and 8 being **least important**.

Improved health _____ Improved endurance _____ Increased strength _____ Sport-specific* _____

Increased muscle mass ____ Fat loss _____ Increased power _____ Weight gain _____

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

_____

Do you have a specific timeline for achieving a specific goal? If so, please specify:

_____

Circle which type of progress is more important to you:

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

Please explain below:

_____

PART 4: EXERCISE INFORMATION

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

EXERCISES:	ADVANCED	INTERMEDIATE	NOVICE	UNFAMILIAR
Barbell squats				
Barbell deadlift				
Barbell bench press				
Bent-over barbell row				
Barbell shoulder press				
Pull-up				
Barbell hack squat				
Olympic movements				
Snatch				
Clean				

Are you currently exercising regularly (at least 3x per week)?

☐ Yes ☐ No

If you answered **YES**, continue on to the following section.

If you answered **NO**, skip ahead to the section marked **"Not currently exercising"**.

Complete this section if you ARE currently exercising regularly

How long have you been consistently exercising without a break?

_____

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

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Type of Exercise							

COMPREHENSIVE CLIENT INFORMATION SHEET

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

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Duration							

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

Complete this section if you ARE NOT currently exercising regularly

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

☐ Yes ☐ No

If you have exercised on a consistent basis previously, how long ago was this and how long did it last? _____

PART 5: MEDICAL AND HEALTH INFORMATION

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

If you are on any medications, please list them. _____

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

_____

If you have any injuries, please list them. _____

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

_____

PART 6: LIFESTYLE INFORMATION

What do you do for a living? _____

What is the activity level at your job?

☐ None (seated work only) ☐ Moderate (light activity such as walking) ☐ High (heavy labor, very active)

Does your job involve shift work?

☐ Yes ☐ No

If you follow a more regular schedule, do you work days, afternoons or nights? _____

Are you a primary caregiver for children, individuals with a disability, or an elder relative?

☐ Yes ☐ No

How often do you travel?

☐ Rarely ☐ A few times a year ☐ A few times a month ☐ Weekly

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

_____

_____

COMPREHENSIVE CLIENT INFORMATION SHEET

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.	

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

How many times per week do you shop for groceries? _____

How many meals do you eat in restaurants and/or fast food places per week? _____

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

If you have any known food allergies, please list them below.

_____

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

_____

COMPREHENSIVE CLIENT INFORMATION SHEET

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

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 two 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.

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

MISCELLANEOUS INFORMATION

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

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

You have now completed our client information sheet. Please bring this, along with your current workout schedule (if applicable) and three-day diet record, to your first appointment.

Three-Day Dietary Record

Name: _____ Date: _____

It is important that this record be both accurate and representative of your normal dietary intake. Thus 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, etc.). To do so, you must follow a few simple instructions (listed below). The purpose here is to correctly record and quantify your normal intake, not to judge it. If you change your eating habits in any way, then we cannot accurately analyze your typical diet. The procedure may seem somewhat cumbersome, but remember, it is only three days.

INSTRUCTIONS

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.

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.

Record combination foods separately (e.g., hot dog, bun, and condiments) and include brand names of food items (list contents of homemade items) whenever possible.

For packaged items, use labels to determine quantities.

Record three 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.

EXAMPLE: DIETARY RECORD: DAY 1

FOOD ITEM	QUANTITY	NOTES
Breakfast		
2 pieces of toast	*2 pc*	
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*

DIETARY RECORD: DAY 1

FOOD ITEM (Include brand names)	**QUANTITY** (g, mL, tablespoons [T], teaspoons [t], cups [c], etc.)	**NOTES** (Include ingredients & amounts of homemade items)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		

DIETARY RECORD: DAY 2

FOOD ITEM (Include brand names)	**QUANTITY** (g, mL, tablespoons [T], teaspoons [t], cups [c], etc.)	**NOTES** (Include ingredients & amounts of homemade items)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		

DIETARY RECORD: DAY 3

FOOD ITEM (Include brand names)	**QUANTITY** (g, mL, tablespoons [T], teaspoons [t], cups [c], etc.)	**NOTES** (Include ingredients & amounts of homemade items)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		

Readiness for Change Questionnaire

Name: _____ Date: _____

One of the most important things you can do to develop new daily practices is to understand your readiness for change. In addition, as your coach, it's useful for me to understand how willing you are to adopt some new practices, as slowly or as quickly as feels right for you.

Simply answer the questions below by selecting the response most appropriate to your situation. Together we'll calculate your score.

READINESS FOR CHANGE QUESTIONNAIRE

QUESTIONS:	RESPONSES AND SCORING
1. Do you look in the mirror and feel frustrated, upset, or humiliated because of how your body looks?	a) Yes (+3) b) I'm not sure (0) c) No (–3)
2. When you feel run down and tired, what do you think is the source of these feelings?	a) Getting older (–1) b) My lifestyle choices (+3) c) 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 two or more of these medications (+3) b) Yes, I'm on only one of these medications (+1) c) No, I'm not on any of these medications (–3)
4. If your fitness has deteriorated over the years, 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) b) I think it's that I'm less active (+3) c) I think it's a natural consequence of aging (–1) 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) b) No (–5)
6. Are you willing to join a gym today?	a) Yes (+3) 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 that are more appropriate to your goal, would you do it?	a) Yes (+5) 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) b) Ask a friend (0) c) Ignore the advice (–3)
9. Are you willing to have a meeting with your friends and loved ones and share your behavior goals and desired outcomes with them?	a) Yes, right away (+5) b) Yes, but not just yet (–3) c) No (–5)

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) 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) 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) 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) b) I know I've got to make some changes but I'll take it one day at a time (+5) 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) b) No (–5)
15. Are you willing to slowly work up to five hours of physical activity each week?	a) Yes (+5) b) No (–5)

YOUR SCORE AND WHAT IT MEANS

21 to 63:

It's clear that you're ready, willing, and able to adopt some new daily practices. Getting to this point is never easy. So congratulations. I look forward to helping you take that enthusiasm and turn it into results.

-20 to +20:

If you scored in this range, it seems like you're on the fence. You may be frustrated with the way things are but a little nervous about changing the way you do things today. Those feelings are totally normal and natural. I'm happy to help you move forward at the right pace for you.

-61 to -21:

From the results of your questionnaire, it seems like you're apprehensive about the change process. And that's totally okay. Most of my new clients experience the same thing, as this area can feel completely foreign to them. At this point, I'm happy to simply provide a healthy environment for you to consider adopting some new daily practices. They can be as small as you like; we'll go at your pace.

Kitchen Makeover Questionnaire

Name: _____ Date: _____

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! Trust us.) 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.

How do you know which foods have got to go and which foods can stay? Simply answer the questions below 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 your kitchen is in good shape.

KITCHEN MAKEOVER QUESTIONNAIRE

QUESTIONS:		RESPONSES AND SCORING
1. Do you have the following items in your kitchen?		
* Good set of pots and pans	* Scale for weighing foods	a) I have all of them. (–5)
* Good set of knives	* Sealable containers for carrying meals	b) I have more than half of them. (–2)
* Spatula	* Small cooler for taking meals to work	c) I have less than half of them. (+2)
* Blender	* Shaker bottle for drinks and shakes	d) I don't have any of them. (+5)
* Tea kettle	* Food processor	
2. Do you have the following items in your pantry?		
* Whole oats	* Extra virgin olive oil	a) I have all of them. (–5)
* Quinoa	* Vinegar	b) I have more than half of them. (–2)
* Whole-grain pasta	* Green tea	c) I have less than half of them. (+2)
* Natural peanut butter	* Protein supplements	d) I don't have any of them. (+5)
* Mixed nuts	* Fish oil/algae oil supplements	
* Canned or bagged beans	* Green foods supplements	
3. Do you have the following items in your fridge or freezer?		
* Extra-lean beef	* At least four varieties of fruit	a) I have all of them. (–5)
* Chicken breasts	* At least five varieties of vegetables	b) I have more than half of them. (–2)
* Salmon	* Flax seed oil	c) I have less than half of them. (+2)
* Omega-3 eggs	* Water filter	d) I don't have any of them. (+5)
* Packaged egg whites	* Sweet potatoes	
* Real cheese	* Tempeh	
4. Do you have the following items in your pantry?		
* Potato or corn chips	* Chocolates or candy	a) I have all of them. (+5)
* Fruit or granola bars	* Soft drinks	b) I have more than half of them. (+2)
* Regular or low-fat cookies	* Regular peanut butter	c) I have less than half of them. (–2)
* Crackers	* At least four types of alcohol	d) I don't have any of them. (–5)
* Instant foods like cake mixes and mashed potatoes		
* Bread crumbs, croutons, and other dried bread products		

KITCHEN MAKEOVER QUESTIONNAIRE

QUESTIONS:	RESPONSES AND SCORING
5. Do you have the following items in your fridge or freezer? * At least four types of sauces * Baked goods * Juicy steaks or sausage * Frozen dinners * Margarine * At least two types of bread or bagel * Fruit juice * Take-out or restaurant leftovers * Soft drinks * Big bowl of mashed potatoes or pasta	a) I have all of them. (+5) b) I have more than half of them. (+2) c) I have less than half of them. (–2) 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) b) No (–5)
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) 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) b) More than half of the time I buy smaller portions. (–3)
9. How often do you shop for groceries?	a) Fewer than three times a month (+5) b) About once a week (–1) c) More than once a week (–5)
10. Do you keep food in plain view around the house?	a) Yes (+3) b) No (–3)
11. Do you think healthy eating means low-fat eating?	a) Yes (+2) 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) 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) b) About half of the time (0) 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) b) More than half the time (–2) c) Less than half the time (+2) 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) b) No, more than half the time I throw this stuff out (0) c) No, I always throw this stuff out (–5)

KITCHEN MAKEOVER QUESTIONNAIRE

YOUR SCORE AND WHAT IT MEANS

32 to 63 points

You scored high on the kitchen makeover questionnaire. But this high score means you may need some adjustments to your kitchen set-up or your shopping habits. That's no problem, though. We'll be working on this together in the coming weeks.

0 to 31 points

Your kitchen environment could also use some improvements. I'll be happy to show you what to do and how to do it as we continue to work together.

-31 to -1 points

You're doing pretty well in the kitchen department. With just a few tweaks, it'll be easier than ever to improve your body composition, energy levels, and performance.

-32 to -63 points

Don't let negative scores fool you. In this questionnaire, negative scores mean a great kitchen environment. Nice work. In the coming week's I'll be happy to share even more strategies for keeping the great kitchen environment going.

Social Support Questionnaire

Name: _____ Date: _____

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 whom you choose to spend your time.

The following questions are designed to assess your level of social support, which strongly influences how well you follow any nutrition or exercise program. Simply answer the questions below 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.

A word of caution: once you recognize your challenges it's easy to blame them for your outcomes. Don't do this. Outside factors can affect you – if you let them. But you're in control. You have the power to place yourself in the right environment, so use it!

SOCIAL SUPPORT QUESTIONNAIRE

QUESTIONS:	RESPONSES AND SCORING
1. Do the people with whom you spend each day (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) b) About half do and half don't. (0) c) No, most of them don't. (–3)
2. Does your spouse or partner follow healthy lifestyle habits such as exercising regularly, watching what s/he eats, and taking nutritional supplements?	a) Yes, my spouse/partner does. (+5) b) No, my spouse/partner doesn't. (–5) 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 you?	a) Yes, it's easy to find a partner. (+2) b) Yes, but very infrequently. (0) c) No, they never do. (–4)
4. At your workplace, do your coworkers regularly bring in treats like cookies, donuts, and other snacks?	a) Yes, they often do. (–4) b) Yes, but I typically don't indulge (0) c) No, they don't (+5)
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) b) Only about half of the time. (0) c) No, they never do. (–2)
6. Do you belong to any clubs, groups, or teams that meet at least twice 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) b) Yes, I've just started. (+2) c) No, I don't. (0)
7. Do you belong to a health club and attend, on average, at least three times per week?	a) Yes, I've been doing this for at least 1 year. (+2) b) Yes, I've just joined. (+1) c) No, I don't. (0)

SOCIAL SUPPORT QUESTIONNAIRE

QUESTIONS:	RESPONSES AND SCORING
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) b) They're not interested. (0) 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) b) Sometimes (–3) c) Never (0)
10. Do the people you live with bring home foods that are considered healthy or good for you?	a) Always (+5) b) Sometimes (0) c) Never (–5)
11. Do the people you live with or work with schedule activities for you that interfere with your pre-established exercise time?	a) Always; they don't respect my time. (–3) b) Sometimes; they don't think about it. (–1) 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) b) Sometimes (+2) c) Never (0)

YOUR SCORE AND WHAT IT MEANS

28 to 38 total points:
Congratulations, it looks like you've got a great social support network around you, a group of people that'll help support your desire to change some of your daily practices. Of course, that's not all you'll need to be successful. But it's a great start.

5 to 27 total points:
It looks like you've got some social support around you but there may be a few areas that will present challenges. Being aware of your social temptations, as indicated above, is a great place to begin. Together we can work on strategies for being successful in the face of those challenges

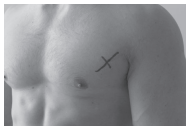
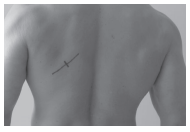
4 to –14 total points:
Your social support is lacking and may need a makeover. However, you're not alone here. Many people struggle with social support. And that's why our coaching together will provide some strategies for enhancing your support network.

–15 to –31 total points:
This score is quite low and may signal some definite challenges in your work and at-home environments, as well as in your relationships. These can often lead to old habits surfacing as many food related problems are really relationship and environment problems. However, this questionnaire will help us isolate the main challenges. And together we'll work on overcoming them.

Initial Body Composition Assessment

Name: _____ Date: _____

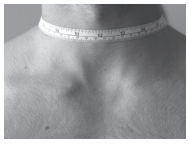
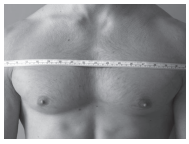
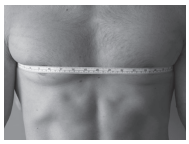
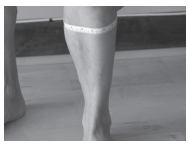
INITIAL BODY COMPOSITION ASSESSMENT (MEN)

SITE	MEASUREMENT #1	MEASUREMENT #2	MEASUREMENT #3	MEAN OF 3 MEASUREMENTS
 Abdominal skinfold (mm)				
 Triceps skinfold (mm)				
 Chest skinfold (mm)				
 Mid-axillary skinfold (mm)				
 Subscapular skinfold (mm)				
 Suprailiac skinfold (mm)				
 Thigh skinfold (mm)				

Sum of mean skinfolds (mm) =

Body fat % (See Appendix A for calculations) =

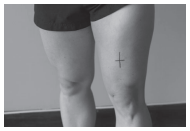
INITIAL BODY COMPOSITION ASSESSMENT (MEN)

SITE	MEASUREMENT #1	MEASUREMENT #2	MEASUREMENT #3	MEAN OF 3 MEASUREMENTS
 Neck girth (cm)				
 Shoulder girth (cm)				
 Chest girth (cm)				
 Upper-arm girth (cm)				
 Waist girth (cm)				
 Hip girth (cm)				
 Thigh girth (cm)				
 Calf girth (cm)				

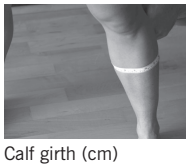
Initial Body Composition Assessment

Name: _____ Date: _____

INITIAL BODY COMPOSITION ASSESSMENT (WOMEN)

SITE	MEASUREMENT #1	MEASUREMENT #2	MEASUREMENT #3	MEAN OF 3 MEASUREMENTS
 Abdominal skinfold (mm)				
 Triceps skinfold (mm)				
 Chest skinfold (mm)				
 Mid-axillary skinfold (mm)				
 Subscapular skinfold (mm)				
 Suprailiac skinfold (mm)				
 Thigh skinfold (mm)				
			Sum of mean skinfolds (mm) =	
			Body fat % (See Appendix A for calculations) =	

INITIAL BODY COMPOSITION ASSESSMENT (WOMEN)

SITE	MEASUREMENT #1	MEASUREMENT #2	MEASUREMENT #3	MEAN OF 3 MEASUREMENTS
 Neck girth (cm)				
 Shoulder girth (cm)				
 Chest girth (cm)				
 Upper-arm girth (cm)				
 Waist girth (cm)				
 Hip girth (cm)				
 Thigh girth (cm)				
 Calf girth (cm)				

Initial Recovery Assessment

Name: _____ Date: _____

BASELINE STRESS/RECOVERY ASSESSMENT

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

MOOD QUALITY	RATING (0–5)
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	

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): _____

Initial Performance Assessment

Name: _____ Date: _____

Regardless of whether you're tracking performance in the gym or on the playing field, many different measures can be used to assess progress. These include maximal strength tests, power tests, strength endurance tests, and endurance capacity tests. Each of these tests will be affected by the quality of the training and nutrition programs you are following, so test them periodically to ensure that they're improving. Collect baseline measures for each of the tests that are relevant to your particular goals, in order to provide a basis for future comparison.

INITIAL PERFORMANCE ASSESSMENT

MAXIMAL STRENGTH TESTS

One great way to assess maximal strength is to perform 1RM (1 repetition maximum) or 3RM (3 repetition maximum) tests in the major lifts – bench press, squat, and deadlift – as these lifts are most indicative of whole-body strength.

Note: if you are relatively new to these movements, you can skip this section, opting to spend time working on technique before testing your strength.

MAJOR LIFT	REPETITIONS	LOAD
Bench press	1RM or 3RM	
Squat	1RM or 3RM	
Deadlift	1RM or 3RM	

POWER TESTS

If increased power is an important goal for you, you may choose to perform 1RM tests in the explosive Olympic lifts: cleans and snatches. You may also want to test your vertical jump for lower body power, and overhead medicine ball toss for upper body power.

Note: if you are relatively new to these movements, you can skip this section, opting to spend time working on technique before testing your strength.

POWER TEST	REPETITIONS	LOAD
Barbell clean	1RM	
Barbell snatch	1RM	

POWER TEST	REPETITIONS	LOAD
Vertical jump	1 jump	
Overhead medicine ball toss	1 toss	

INITIAL PERFORMANCE ASSESSMENT

STRENGTH-ENDURANCE

Another valuable test that can demonstrate progress in strength-endurance is a percent of 1RM test. In this type of test, you select a weight that's 75% of your 1RM and perform as many reps as you can.

Note: choose the same weight for your baseline testing as you do for your follow-up testing. For example, don't select 75% of your new 1RM when you retest. Choose 75% of your original 1RM. In other words, if you use 225 lb for this first assessment, make sure that each follow-up test is performed with 225 lb. This will help you accurately gauge progress over time.

MAJOR LIFT	MAX	% OF MAX	LOAD	REPETITIONS
Bench press				
Squat				
Deadlift				

ENDURANCE CAPACITY

While VO^2_{max} testing and aerobic/anaerobic threshold testing are popular measures of endurance capacity, a simple in-gym treadmill procedure can be used to measure endurance progress. Here's how it's done:

1. Start by running on the treadmill at a speed between 7.5 and 8.5 mph and a 0% elevation.
2. Increase the elevation by 1% every minute.
3. Continue until exhaustion.
4. Record the highest achieved elevation.

This number is V_{max} (maximum velocity). Most young, active people can last until they reach between 8% and 12% elevation.

Over time, you can retest your V_{max} for a good index of your aerobic capacity. You'll know you've improved if you can last longer and achieve a higher incline. If you want to go one step further, here's another good test:

1. After a day off from the gym, begin by setting the treadmill at the same speed and grade as your V_{max}.
2. Run on the treadmill at V_{max} until fatigue.
3. Record your maximum time at $V_{max.}$ This duration is called T_{max} (maximum time).

Most athletes can last between 200 and 300 seconds. As with V_{max}, you can retest T_{max} over time as another good index of endurance capacity.

Note: choose the same V_{max} for pretesting and follow-up testing. In other words, if you can last for 200 seconds at 10% elevation and 8.5 mph during the pretest, make sure that you use 10% elevation and 8.5 mph during your second test. This will help you accurately gauge progress over time.

TEST	SPEED	ELEVATION
V_{max}		

TEST	TIME AT V_{max}
T_{max}	

Baseline Blood Chemistry Assessment

Name: _____ Date: _____

A complete blood profile test, performed by your doctor, will assess your overall blood and cellular health as well as your susceptibility to disease. We recommend the following tests. Please bring this list to your physician and inquire about having these tests done. Once this information is collected, include this information in your file for comparative data over time.

BASELINE BLOOD CHEMISTRY ASSESSMENT

GENERAL TESTS

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. This test is standard and should be done although it's not very telling of your overall health profile.

CARDIOVASCULAR RISK PROFILE

- Total cholesterol
- LDL
- HDL
- Triglycerides
- C-reactive protein
- Homocysteine

HORMONES

- Testosterone
- Free testosterone
- IGF-1
- Growth hormone
- DHEA/DHEAs
- Estradiol
- SHBG

PROSTATE TESTS

- PSA

CARBOHYDRATE TOLERANCE

- Fasted insulin
- Fasted glucose

LIVER FUNCTION TESTS

- Alkaline phosphatase
- GGT
- SGOT
- SGPT
- Bilirubin

KIDNEY FUNCTION TESTS

- Creatinine
- BUN
- Creatinine/BUN ratio

THYROID PANEL

- TSH
- T3
- T4
- rT3

Appetite Awareness Worksheet

The "How You Should Feel Timeline"

Today you're going to eat what you feel is a "typical" meal and then observe how you feel immediately after finishing and every hour afterward. If you've eaten the right amount for fat loss, you might feel like this:

HOUR 0

Immediately after

You're probably still a little hungry. It will take roughly 15-20 minutes to get a sense of satisfaction from a meal. If you're a fast eater, wait it out before you go for more.

HOUR 1

One hour after finishing

You should still feel satisfied with no desire to eat another meal.

HOUR 2

Two hours after finishing

You may start to feel a little hungry, like you could eat something, but the feeling isn't overwhelming.

HOUR 3

Three to four hours after finishing

You should feel like it's time for the next meal. Your hunger should be around a 7 or 8 out of 10 (where 10 is the hungriest you've ever been), but may be more or less depending on when you exercised and what your daily physical activity level is.

Not really hungry yet? You likely had too much food at your previous meal.

HOUR 4

Four or more hours after finishing

You're quite hungry, like nothing is getting between you and the kitchen. You're at 8 or 9 out of 10. This is when the "I'm so hungry I could eat anything" feeling appears.

(Obviously, if you let your hunger get this far you may make poor choices.)

How Hungry Am I?

This worksheet helps you get into the habit of noticing how physically hungry or full you are.

Look for physical cues such as:

- growling stomach or sense of stomach emptiness
- lightheadedness
- irritability, shakiness
- headache

The more you practice observing your physical hunger cues (and differentiating them from just wanting to eat), the better you will get.

GOALS

1. Eat scheduled meals/snacks. Avoid getting too hungry.
2. Resist urges to eat when not hungry. Stop at 80% full.
3. Describe physical and emotional feelings around eating times.
4. Be aware of non-physical eating cues.

HOW TO USE THIS SHEET

1. Mark two boxes for each meal: how hungry you are when you start eating, and how hungry you are when you finish eating.
2. Describe your physical and emotional sensations. For physical sensations, focus on how your stomach feels in particular.

EXAMPLE

1 = extremely hungry; 4 = neutral; 7 = overstuffed/sick

DATE	TIME	TOO HUNGRY	MINDFUL EATING	TOO FULL	NOTES
Jan 14/10	12 pm	☑1 ☐2	☐3 ☐4 ☐5	☐6 ☑7	Starving when I started out... didn't eat breakfast. Over-ate. Feel really gross and full now; upset stomach.
	5 pm	☐1 ☑2	☐3 ☐4 ☐5	☑6 ☐7	Didn't stop soon enough; feel sluggish and bloated.
	9:00 pm	☐1 ☐2	☑3 ☐4 ☑5	☐6 ☐7	Feel good. Went to the store and bought some nice berries to eat. Stomach upset subsiding.

HOW HUNGRY AM I?

1 = extremely hungry; 4 = neutral; 7 = overstuffed/sick

DATE	TIME	TOO HUNGRY	MINDFUL EATING	TOO FULL	NOTES
		☐1 ☐2	☐3 ☐4 ☐5	☐6 ☐7	
		☐1 ☐2	☐3 ☐4 ☐5	☐6 ☐7	
		☐1 ☐2	☐3 ☐4 ☐5	☐6 ☐7	
		☐1 ☐2	☐3 ☐4 ☐5	☐6 ☐7	
		☐1 ☐2	☐3 ☐4 ☐5	☐6 ☐7	

CUT ALONG LINE

FOLD HERE

FOLD HERE

PRECISION NUTRITION

5 Habits
Cheat Sheet

FOLD HERE

FOLD HERE

Answer
each question
according to
the 5 Habits...

CUT ALONG LINE

CUT ALONG LINE

1. Are you eating slowly?

Check in with hunger, sit down, relax and take your time; 15-20 minutes for a meal is about right. Make sure to stop eating when you're about 80% full.

2. Where is the protein dense food?

Are you about to eat at least 1 palm-sized portion of protein dense food? Women get 1 palm-sized portion and men get 2 palm-sized portions.

FOLD HERE

FOLD HERE

3. Where are the veggies?

Are you about to eat a large portion of veggies? They can be prepared any way you like. One serving is about 1 fist-sized portion and you should try to eat a few portions per meal.

4. Where are the carbs?

If you have fat to lose but haven't just worked out, eat less pasta, bread, rice, and other starchy carbs. Opt for a double serving of veggies instead. If you have just worked out, a mix of carb sources is fine.

5. Where are your fats coming from?

Today you need some fats from various foods, prioritizing whole food sources like eggs, meats, fish, olives, nuts and seeds. Spread these throughout the day.

FOLD HERE

FOLD HERE

CUT ALONG LINE

PrecisionNutrition

Protein, Fat and Carbohydrate Chart

PROTEIN CHART

Food type	Protein dense foods
Food timing	Eaten with each meal
Food amount	1 serving for women (size of palm) 2 servings for men (size of two palms)

Examples	• Lean meats such as ground beef, chicken, turkey, bison, venison
	• Fish such as salmon, tuna, cod, roughy
	• Eggs
	• Dairy such as cottage cheese, Greek yogurt, cheese, etc.
	• Beans, peas, legumes, tofu, tempeh, etc.
	• Protein supplements
	  • milk-based: whey, casein, milk protein blends
	  • plant-based: pea, hemp, rice, soy, etc.

FAT CHART

FOOD TYPE	SATURATED FAT	MONOUNSATURATED FAT	POLYUNSATURATED FAT
Food timing	No specific timing[1]	No specific timing[1]	No specific timing[1]
Food amount	1/3 of intake	1/3 of intake	1/3 of intake
Examples	Animal fats (in eggs, dairy, meats, butter, cheeses, etc.) Coconut oil Palm oil	Macadamias, pecans, almonds, cashews, pistachios, tahini, pumpkin seeds, hazelnuts olives, olive oil, avocado	Fish oil, hemp seeds, algae oils, safflower oil, sunflower seeds, peanuts, canola oil, soy nuts, walnuts, flax seeds, flax oil, chia seeds, Brazil nuts

1. As discussed earlier in the text, meals higher in carbohydrate should likely be lower in fat, and vice versa. Therefore if eating a higher carbohydrate post-exercise meal, fat intake would be lower. Conversely, with a higher-fat meal outside of the "workout window", carbohydrate portion should be relatively smaller.

2. For those consuming less overall food and/or consuming a plant-based diet, getting more fat from whole food sources (like olives, nuts, seeds) instead of refined sources (olive oil, nut oil, seed oil) will provide more protein and fiber.

CARBOHYDRATE CHART FOR FAT LOSS AND MUSCLE GAIN

FOOD TYPE	EXERCISE RECOVERY DRINK	SIMPLE SUGARS AND HIGHLY PROCESSED STARCHES	WHOLE-FOOD, MINIMALLY PROCESSED STARCHY CARBOHYDRATES	FRUITS AND VEGETABLES
FOOD TIMING				
For muscle gain	During and after exercise	Immediately after exercise (if at all)[2]	Eat soon (within 3 hours) after exercise[3]	Eaten with each meal
FOOD TIMING				
For fat loss	During exercise only[1]	Minimize intake	Eat soon (within 1-2 hours) after exercise	Eaten with each meal (with emphasis on veggies)
Examples	Sugary, protein-rich recovery drinks such as Biotest Surge, Endurox R4	Sugary sports drinks Breakfast cereals Soda Fruit juice Table sugar Sugary desserts Ice cream Muffins Bagels Other carbohydrate-rich snacks	Bread (preferably whole grain) Pasta (preferably whole grain or flax) Rice (preferably whole grain, unprocessed) Potatoes Oats (preferably whole oats) Cereal grains (wheat, rye, etc.)	Spinach Carrots Tomatoes Broccoli Cauliflower Apples Oranges Avocados Berries

Notes:

1. If your client tolerates carbohydrates well, you can include such a drink during exercise. If your client doesn't, you should probably stick with water or a branched-chain amino acid workout drink (to be discussed later in the course).
2. These food choices should be minimized yet are permissible after exercise for those with good carbohydrate tolerance and the goal of weight gain.
3. If a client has good carbohydrate tolerance and a hard time gaining weight, you can include these foods throughout the rest of the day as well.

Simplified carbohydrate chart for fat loss or maintenance

CARB TYPE	EXAMPLES	WHEN TO EAT
Fibre-rich	vegetables (e.g., broccoli, kale, spinach, carrots, tomatoes, celery, cucumber, zucchini, beets, bok choy, lettuce, collards, radish, onion, chard, watercress, etc.) peas beans* legumes* most fruits*	Eat often, and any time of day (especially for veggies)
Whole food starchy	sprouted or whole grain breads and pastas corn yams/sweet potatoes/pumpkin quinoa amaranth oats long grain rice	During the 3 hours after exercise
Refined sugary	desserts fruit juice processed foods soda sports drinks most commercial nutrition bars dates, figs, raisins, dried fruits	Eat occasionally/rarely, and only during the 3 hours after exercise

*Notes: These selections are more carb-dense. So, when including these in meals, be sure not to overeat

21 Superfoods Reference Guide

21 SUPERFOODS REFERENCE GUIDE

PROTEINS	1. Lean red meat (grass-fed preferred)
	2. Salmon (wild caught preferred)
	3. Eggs (omega-3 and cage free preferred)
	4. Plain Greek yogurt, cottage cheese, or coconut milk yogurt
	5. Protein supplements (whey, milk or plant protein sources)
VEGETABLES AND FRUITS	6. Spinach
	7. Tomatoes
	8. Cruciferous vegetables (broccoli, cabbage, cauliflower)
	9. Mixed berries
	10. Oranges
OTHER CARBOHYDRATES	11. Mixed beans
	12. Quinoa
	13. Whole oats
GOOD FATS	14. Raw, unsalted mixed nuts
	15. Avocados
	16. Extra virgin olive oil
	17. Fish oil (or algae oil)
	18. Flax seeds (ground)
DRINKS / OTHER	19. Green tea
	20. Liquid exercise drinks (or branched-chain amino acids)
	21. greens+® (vegetable concentrate)

Note:

1. Do not select foods that you are allergic to or intolerant of.
2. For a plant-based superfoods reference guide, please see the Plant-Based Diet Guide as part of Precision Nutrition V3 (www.precisionnutrition.com)

21 Superfoods Checklist

21 SUPERFOODS CHECKLIST

FOOD TYPE	FOOD CATEGORY	# OF SERVINGS
1. Lean red meat (grass-fed preferred)	Protein - Lean meat	
2. Salmon (wild caught preferred)	Protein - Fish	
3. Eggs (omega-3 and cage free preferred)	Protein - Egg	
4. Plain Greek yogurt, cottage cheese, or coconut milk yogurt	Protein - Dairy	
5. Protein supplements (whey, milk or plant protein sources)	Protein - Powder	
6. Spinach	Carb - Vegetable	
7. Tomatoes	Carb - Vegetable	
8. Cruciferous vegetables (broccoli, cabbage, cauliflower)	Carb - Vegetable	
9. Mixed berries (strawberries, blueberries, raspberries, etc.)	Carb - Fruit	
10. Oranges	Carb - Fruit	
11. Mixed beans/peas (black beans, lentils, split peas, etc.)	Carb/Protein – Legume	
12. Quinoa	Carb - Grain	
13. Whole oats (large flake)	Carb - Cereal	
14. Raw, unsalted mixed nuts (a variety including pecans, walnuts, cashews, brazil nuts, etc.)	Fat - Seeds and nuts	
15. Avocados	Fat - Fruit	
16. Olive oil (extra virgin)	Fat - Oils	
17. Fish oil (salmon, anchovy, menhaden, krill) or algae oil	Fat - Oils	
18. Flax seeds (ground)	Fat - Seeds and nuts	
19. Green tea	Teas	
20. greens +® or comparable blend	Vegetable concentrate	
21. Liquid exercise drinks (or branched-chain amino acids)	Recovery drinks	

Note:

1. Do not select foods that you are allergic to or intolerant of.
2. For a plant-based superfoods checklist, please see the Plant-Based Diet Guide as part of Precision Nutrition V3 (www.precisionnutrition.com)

Bi-weekly Adherence Chart

Name: _____ Date: _____

Each time you eat a compliant meal, put an **X** in the appropriate box.

Each time you miss a meal, put an **O** in the appropriate box.

Each time you eat a noncompliant meal, put an ***** in the appropriate box.

If a meal isn't applicable, put a **N/A** in the appropriate box.

BI-WEEKLY ADHERENCE CHART

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							

Bi-weekly Client Report

Name: _____ Date: _____

INSTRUCTIONS

In order to provide the best possible service, it is important that you fill out all the information below. Keep a daily record of bodyweight and recovery measures. Please bring this report to your next check-up meeting. I'll collect your skinfold measures and girths during this meeting, so you can leave those sections blank.

DISCLAIMER

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 agree to accept full responsibility for your decision.

Body Composition Measures

1. Bodyweight (in lb)

WEEK 1	WEIGHT	WEEK 2	WEIGHT
Monday		Monday	
Tuesday		Tuesday	
Wednesday		Wednesday	
Thursday		Thursday	
Friday		Friday	
Saturday		Saturday	
Sunday		Sunday	

2. Your body fat percentage (I'll take this during your session). _____

3. Please provide the following skinfold measures (in mm)*.

SKINFOLD SITE	MEASUREMENT (MM)
Abs	
Subscapularis	
Triceps	
Suprailiac	
Chest	
Thigh	
Mid-axillary	

4. Please provide the following girth measurements (inches or cm)*.

LOCATION	GIRTH MEASUREMENT
Neck	
Shoulder	
Chest	
Upper-arm	
Waist	
Hip	
Thigh	
Calf	

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

Goals

1. 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 important.

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

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

2. Is there a specific timeline for achieving your goals? If so, please describe in detail.

3. What's more important to you:

☐ a. Immediate progress that's less easily maintained *OR* ☐ b. Maintainable progress that may not be as rapid

Please explain below:

Subjective recovery measures

Please rate (daily) each of the following variables on a scale of 0 - 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

WEEK 1	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Appetite							
Sleep quality							
Tiredness							
Willingness to train							

WEEK 2	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Appetite							
Sleep quality							
Tiredness							
Willingness to train							

Objective recovery measures

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

WEEK 1	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Pulse (bpm)							

WEEK 2	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Pulse (bpm)							

Perceived appearance

What changes in your appearance do you see when you look in the mirror? Please describe them in your own words. (For example, are you getting tighter, more muscular, or more vascular?)

Gym performance

Subjective appraisal

How are your workouts 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 may have about the workout.

General nutrition perceptions

How is your nutritional program going? Are you having difficulty following it or is it easy to eat this way? How successfully have you avoided unhealthy choices and made more positive eating decisions?

Adherence to nutrition plan

Please place an "X" only in squares corresponding to the day and meal where you followed the nutrition plan, as prescribed, 100%**. Please input a "N/A" in boxes that don't apply to you (for example, if you are only required to eat 5 meals per day, put N/A in the 6, 7 and 8 columns). The order of your meals isn't important. 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 fit your schedule better, you'd still place an X for each meal).**

	WEEK 1								WEEK 2							
MEAL	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Monday																
Tuesday																
Wednesday																
Thursday																
Friday																
Saturday																
Sunday																

Are you having any problems with adherence, or does it seem easy? Please elaborate below.

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

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

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

How often have you eaten out in restaurants per week?

General wellbeing

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

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

Follow-up Performance Assessment

Name: _____ Date: _____

MAXIMUM STRENGTH TESTS

	SESSION 1 (BASELINE)		SESSION 2		SESSION 3	
MAJOR LIFT	**REPS**	**WEIGHT**	**REPS**	**WEIGHT**	**REPS**	**WEIGHT**
Bench press						
Squat						
Deadlift						

POWER TESTS

MAJOR LIFT	**REPS**	**WEIGHT**	**REPS**	**WEIGHT**	**REPS**	**WEIGHT**
Barbell clean						
Barbell snatch						
	HEIGHT / DISTANCE		**HEIGHT / DISTANCE**		**HEIGHT / DISTANCE**	
Vertical jump						
Overhead medicine ball toss						

STRENGTH ENDURANCE TESTS

	SESSION 1 (BASELINE)				SESSION 2 (FOLLOW-UP)			
MAJOR LIFT	**1RM LOAD**	**% OF MAX**	**LOAD**	**REPS**	**1RM LOAD**	**% OF MAX**	**LOAD**	**REPS**
Bench press								
Squat								
Deadlift								

V_{MAX}

SESSION 1 (BASELINE)		SESSION 2		SESSION 3	
FINAL SPEED	FINAL ELEVATION	FINAL SPEED	FINAL ELEVATION	FINAL SPEED	FINAL ELEVATION

T_{MAX}

	SESSION 1 (BASELINE)	SESSION 2	SESSION 3
Time at initial V_{max}			
Time at new V_{max}			

Limiting Factors and Behavior Goals (Trainer's Log)

Name: _____ Date: _____

Limiting factors and behavior goals (trainer's log)

DATE	LIMITING FACTORS	BEHAVIOR GOALS

Urine Color Chart

The Urine Color Chart shown here will assess your hydration status (level of dehydration) in extreme environments. To use this chart, match the color of your urine sample to a color on the chart. If the urine sample matches #1, #2, or #3 on the chart, you are well hydrated. If your urine color is #7 or darker, you are dehyrated and should consume fluids.