

Client Intake & Readiness Questionnaire

All information remains confidential and is used solely to design a safe and effective training plan.

Begin Your Journey

Welcome to Gravity Laboratory. Gravity is a coaching-led movement and strength studio designed for people who want to move better, become stronger, and build lifelong physical capability.

We're selective about how people begin - not because we're exclusive, but because matching each person with the right starting pathway produces better long-term outcomes.

Every prospective member begins with a Readiness Review and a complimentary No Sweat Intro with one of our coaches.

This helps us understand your goals, your experience, and allows us to recommend the best starting pathway - whether that's personal coaching, membership, or one of our introductory or specialist programs.

We look forward to learning more about you.

SECTION 1 — Participant Information & Basic Health Screening

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Occupation: _____ Years worked: _____

Gender: M / F Medical clearance needed?: Y / N

1. Are you currently under the care of any healthcare provider for an injury, medical condition, or physical limitation?

☐ Yes ☐ No

If yes, specify provider type (e.g., Physio, Chiro, MD): _____

Condition being treated: _____

If treatment involves movement restrictions, we may request "Clearance to Exercise" from your clinician to ensure safe programming.

2. Do you currently have pain, discomfort, or limitation in any of the following areas?

(Check all that apply)

☐ Shoulder ☐ Elbow ☐ Wrist/Hand ☐ Neck ☐ Upper Back ☐ Lower Back

☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Other: _____

Describe how it affects movement: _____

3. Have you been advised by a health professional to avoid or modify exercise?

☐ Yes ☐ No

If yes, please describe: _____

4. Have you had surgery or major injury within the past 12 months?

☐ Yes ☐ No

If yes, specify procedure and date: _____

5. Please check any current medical conditions we should be aware of:

(Note, these are only categories relevant to exercise safety - no diagnosis details required)

☐ Cardiovascular concerns (e.g., high BP, heart condition)

☐ Metabolic conditions (diabetes, thyroid, blood sugar issues)

☐ Respiratory conditions (asthma, COPD)

☐ Neurological conditions (e.g., migraines, balance disorders)

☐ Bone/joint conditions (arthritis, osteoporosis)

☐ Other relevant condition: _____

6. Do you smoke or vape?

☐ Yes ☐ No

7. Are you currently pregnant or postpartum within the last 12 months?

☐ Yes ☐ No

SECTION 2 — Medications & Supplements

We only need information that affects exercise response or safety.

1. Are you taking any medications that impact heart rate, blood pressure, pain response, or energy levels?

☐ Yes ☐ No

If yes, list medication name(s) only: _____

2. Do you take any supplements we should be aware of for exercise tolerance?

☐ Yes ☐ No

If yes, list types (e.g., creatine, pre-workout, energy boosters): _____

SECTION 3 — Movement, Lifestyle & Training Background

1. How would you describe your current physical activity level?

☐ Beginner (0–1x/week)

☐ Occasional (1–2x/week)

☐ Regular (3x/week)

☐ Advanced (4+ sessions/week)

2. Which activities or sports do you currently do (if any)?

3. How would you describe your day-to-day activity level?

☐ Mostly seated

☐ Mixed standing/walking

☐ Highly active / manual work

4. Do you have experience with any of the following?

(Check all that apply)

☐ Strength Training - Bodyweight

☐ Strength Training - Weighted

☐ Mobility Training

☐ Handstands

☐ Movement Training

☐ Rowing/ergs

☐ None of the above

SECTION 4 — Stress, Sleep & Recovery

1. How would you rate your daily stress levels?

(1 = Low, 5 = High)

1 2 3 4 5

2. How many hours of sleep do you get on average?

☐ <5 ☐ 5–6 ☐ 6–7 ☐ 7–8 ☐ >8

3. Do you currently experience chronic fatigue or burnout symptoms?

☐ Yes ☐ No

If yes, describe: _____

SECTION 5 — Nutrition Snapshot

1. How would you describe your eating pattern?

☐ Structured meals

☐ Grazing/snacking

☐ Irregular meal timing

☐ Mixed

2. Do you regularly:

☐ Eat breakfast

☐ Drink 6–8 cups of water/day

☐ Consume alcohol (approx. drinks/week): _____

3. Are there any nutritional considerations we should know when planning training?

(e.g., fasting windows, digestive sensitivities, hydration issues)

SECTION 6 — Availability & Logistics

Days available for training:

☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Preferred time windows:

(Select all that apply)

Morning:

☐ 6:00–8:00am

☐ 8:00–10:00am

☐ 10:00am–12:00pm

Afternoon:

☐ 12:00–2:00pm

☐ 2:00–4:00pm

☐ 4:00–6:00pm

Evening:

☐ 6:00–7:00pm

☐ 7:00–8:30pm

If you have specific time constraints or preferences, please note them below:

Which coaching experience interests you the most?

☐ Personal Training ☐ Group Classes ☐ Combination ☐ Unsure

SECTION 7 — Goals & Expectations

1. What are your goals / reason for training at Gravity?

Not ———> Somewhat ———> Extremely Important

Strength	1	2	3	4	5
Mobility & Flexibility	1	2	3	4	5
Skill Development	1	2	3	4	5
Body Composition	1	2	3	4	5
Aerobic (Cardiorespiratory) Conditioning	1	2	3	4	5
Increase Energy Levels	1	2	3	4	5
Maintain Workout Consistency	1	2	3	4	5
Performance for Specific Sport / Activity	1	2	3	4	5
Health Aging / Longevity	1	2	3	4	5

2. What is the #1 goal that matters most to you right now?

3. What are the main barriers to reaching this goal?

4. What would success look or feel like after 3 months of training / 9 months of training?

5. Are there any exercises you particularly enjoy or dislike?

Enjoy: _____

Prefer to avoid: _____

For Coach Use Only

Recommended Starting Pathway

- ☐ Personal Training (PT)
- ☐ PT + Classes
- ☐ Membership
- ☐ Foundations
- ☐ Referral Required

Coach: _____

Reason for recommendation:

Follow-up date: _____

