

JAKE'S FITNESS READINESS TEST

A professional intake to guide safer, more personalized coaching.



CLIENT PROFILE

Name: _____

Date: _____

Age: _____

Height: _____

Weight: _____

Phone / Email: _____



PRIVATE PAGE

01 What are your top 3 health or fitness goals for the next 12 months?

02 Do you have any physician-diagnosed medical conditions or current health concerns that may affect exercise or nutrition?

☐ No ☐ Yes

03 Are you currently taking prescription medications, over-the-counter medicines, or supplements that could affect exercise, appetite, hydration, heart rate, blood pressure, or recovery?

☐ No ☐ Yes

04 Have you had surgery, hospitalization, a major injury, or a significant change in health during the past 12 months?

☐ No ☐ Yes

SAFETY NOTE: This form supports coaching; it does not diagnose disease or replace medical care.



MOVEMENT & FITNESS BASELINE

Build the program around what your body can do today - then progress.

WEEKLY ACTIVITY BENCHMARK

General adult guideline: 150 min moderate aerobic activity + 2 strength days/week.

Strength days		2
Aerobic minutes		150

05 How many days per week do you currently perform purposeful exercise?

- ☐ 0
- ☐ 1-2
- ☐ 3-4
- ☐ 5+

06 About how many total minutes of moderate-to-vigorous aerobic activity do you complete in a typical week?

- ☐ <30
- ☐ 30-74
- ☐ 75-149
- ☐ 150-299
- ☐ 300+

07 How many days per week do you perform resistance or strength training?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3+

08 Do you currently experience pain, dizziness, unusual shortness of breath, fainting, chest discomfort, or joint instability during activity?

- ☐ No
- ☐ Yes

If yes, describe what happens, when it happens, and whether a clinician has evaluated it.

09 Which activities do you enjoy enough to repeat consistently? What movements do you dislike or need modified?



NUTRITION & WEIGHT MANAGEMENT

Look for patterns - not perfection. Sustainable habits beat extreme plans.

THE WEIGHT-MANAGEMENT FOUNDATION

NUTRITION

food pattern

ACTIVITY

movement

SLEEP

recovery

STRESS

consistency

Gradual weight loss of about 1-2 lb/week is commonly recommended for people pursuing weight loss.

10 Describe a typical weekday of eating and drinking, from waking through bedtime.

11 How often do you eat fruits and vegetables, lean or plant proteins, and minimally processed whole foods?

☐ Rarely ☐ Some days ☐ Most days ☐ Daily

12 How often do restaurant meals, takeout, sweets, sugary drinks, alcohol, or highly processed snacks appear in your week?

13 Have you recently had major weight change, loss of appetite, binge-type eating, food allergies/intolerances, or a medically prescribed diet?

☐ No ☐ Yes

14 What is your current weight goal, and what would success look like beyond the scale (energy, strength, waist, labs, confidence, performance)?



RECOVERY, SLEEP & LIFESTYLE

Training only works when recovery, schedule, and daily habits support it.

SLEEP TARGET FOR MOST ADULTS

7-9

HOURS / NIGHT

Sleep supports recovery, attention, mood and cardiovascular health.

DAILY READINESS



15 How many hours of sleep do you average, and how rested do you feel when you wake?

☐ <5 ☐ 5-6 ☐ 7-9 ☐ >9

16 What are your biggest barriers to consistency (work schedule, caregiving, travel, pain, fatigue, access, motivation, food environment, other)?

17 How many hours per day are you usually sedentary outside of sleep? How often do you take movement breaks?

18 Do you currently use nicotine, cannabis, alcohol, stimulants, or other substances that your coach should consider when planning training, hydration, sleep, or recovery?

☐ No ☐ Yes / prefer to discuss



YOUR 90-DAY ACTION MAP

Turn the intake into a clear starting point for coaching.

SELF-RATING: CIRCLE 1-5

Energy

① ② ③ ④ ⑤

Strength

① ② ③ ④ ⑤

Cardio fitness

① ② ③ ④ ⑤

Nutrition consistency

① ② ③ ④ ⑤

Sleep quality

① ② ③ ④ ⑤

Stress management

① ② ③ ④ ⑤

- 19** What is the single most important result you want in the next 90 days, and why does it matter now?

- 20** What level of coaching accountability would help you most, and what could cause you to stop following the plan?

COACH REVIEW / STARTING PLAN

PRIMARY GOAL

TRAINING FREQUENCY

NUTRITION FOCUS

RECOVERY FOCUS

MEDICAL CLEARANCE / REFERRAL NOTES

READY TO BUILD YOUR PLAN?

Scan Jake's private page and keep your coaching resources in one place.

Client signature: _____

Date: _____



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Educational coaching intake only. Not medical diagnosis or treatment. Seek qualified medical care for symptoms, medical conditions, medication questions, or exercise clearance when appropriate.

