



TRIATHLETE QUESTIONNAIRE

Contact Information	
Name	
Address	
Email	
Phone (s)	
Fax	
Contact preference (email, phone, text)	
Emergency contact (email, phone)	

Medical History	
Date of birth	
Gender	
Height	
Weight	
Is this your normal weight?	
Resting heart rate	
Resting blood pressure	
Conditions / Chronic diseases	
Have you ever had any of the following:	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Back / joint pain	<input type="checkbox"/> Kidney infection
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Infectious mono
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Head injury
<input type="checkbox"/> Angina / chest pain	<input type="checkbox"/> Other - specify
Are you suffering from a heart condition (heart attack, angina, irregular beat, hole in heart etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel pain in the chest when performing physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from high or low blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Are you taking medication to control your blood pressure or a heart condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a back or joint problem that could be made worse through physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you knowingly suffer from Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from respiratory illness (asthma, bronchitis, emphysema) or have a shortness of breath with mild exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you under medical treatment for any illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For ladies only: Are you pregnant, or have you had a child in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgeries?	
Medications?	
Allergies?	
Injuries (bones, joints, muscle) and / or surgeries?	
Treatment for injuries?	
What aggravates injuries?	
Any (safety) issue/s that would affect training program?	
History or medical issues during exercise?	

Lifestyle	
Work	
Family	
Hobbies	
Travel	
Amount of vacation / time off	
Number of hours per week exercising	
Preferred time of day exercising	
Access to pools / water	
Access to biking (outdoor / indoor)	
Access to running (outdoor / indoor)	



TRIATHLETE QUESTIONNAIRE

Exercise schedule / availability							
	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Time Available							
Swim							
Bike							
Run							
Weights							

Dietary	
Number of meals per day	
Calories intake (if known)	
Modified diet / restrictions	
Food preferences	
Dietary supplements (vitamins, herbs, minerals, protein, replacements)	

Psychological [1 = Poor 2 = Fair 3 = Good 4 = Very Good 5 = Excellent]						
	1	2	3	4	5	Comment
Self-awareness						
Level of confidence to complete a race						
Ability to set goals and targets						
Ability to follow through with goals						
Use of visualisation / imagery to prepare for a race						
Use of self-talk / thought control						
Ability to pay attention / focus under stress						
Ability to endure peak sensation						
Ability to excel under pressure						
Ability to make decisions under stress						
Consistency						
Ability to take recovery days without guilt						



TRIATHLETE QUESTIONNAIRE

Triathlon History	
Date 1 st triathlon completed	
Number of triathlons completed	
Longest distance completed - What - Total time - Splits	
Other endurance events	
Qualifications / honours	
Goals	

Athletic history (other than triathlons)	
Other endurance events	What: When: Time / ranking: What: When: Time / ranking: What: When: Time / ranking: What: When: Time / ranking:
Other types of exercise / physical activities	
Type of organised sports (current)	
Types of organised sports (past)	



TRIATHLETE QUESTIONNAIRE

Triathlon and other events for season	
Priority:	Race:
	Race name: Race date: Race distance:
	Race name: Race date: Race distance:
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Swimming	
Years swimming?	
Total weekly distance?	
Weekly frequency?	
Longest swim? (to date)	
Organised program?	
Planned workouts?	
Swim capability?	
What do you think are your limiters?	
What do you think are your strengths?	
What equipment do you own?	
Access to pool / water?	

Biking	
Years biking?	
Total weekly distance?	
Weekly frequency?	
Longest bike? (to date)	
Organised program? Racing club?	
Planned workouts?	
Bike capability? (time / distances)	
What do you think are your limiters?	
What do you think are your strengths?	
What equipment do you own?	
Access to riding? (indoor /outdoor)	
Do you ride in a group?	



TRIATHLETE QUESTIONNAIRE

Running	
Years running?	
Total weekly distance	
Weekly frequency	
Longest run (to date)	
Organised program? Racing club?	
Planned workouts?	
Run capability (time / distances)	
What do you think are your limiters?	
What do you think are your strengths?	
What equipment do you own?	
Access to running (outside / inside)	

Strength and conditioning	
Describe your current strength and conditioning program (include organised classes, frequency and duration).	
Which of the following types of equipment do you have access to?	<input type="checkbox"/> Weight machines
	<input type="checkbox"/> Free weights (dumbbells and barbells)
	<input type="checkbox"/> Cable machines
	<input type="checkbox"/> Elastic resistance (rubber tubing and bands)
	<input type="checkbox"/> Medicine balls
	<input type="checkbox"/> Kettle bells
	<input type="checkbox"/> Suspension trainers
	<input type="checkbox"/> Stability balls (including half-dome)
Does your occupation require extended periods of sitting?	
Does your occupation require extended periods of repetitive movements? (If yes, please explain)	
Does your occupation require you to wear shoes with a heel? (dress shoes)	

Other notes: