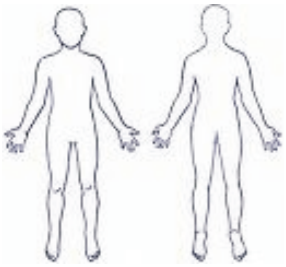
HEALTH & FITNESS

healthy bodies - healthy minds - healthy lives

CLIENT INFORMATION

Are you male, over 45 years old? Yes / No Are you postmenopausal? Yes / No Are you a smoker? Yes / No Is your BP > than 140 / 90 mmHg? Yes / No Do you take BP medication? Yes / No Do you have cholesterol > 240 mg/dl? Yes / No	Do you have a family history of heart attack or any heart conditions? Yes / No Are you a diabetic? Yes / No Are you physically inactive? Yes / No Do you have epilepsy? Yes / No Do you have asthma? Yes / No
(if you marked yes to two or more of these questions you may have to visit your doctor prior to commencing an exercise programme)	**If not then lets get started on your *REAL* exercise programme!**
Do you take prescription medications, pills, tablets or supplements?	Yes / No
Do you have any joint problems, aches or pains? Yes / No	If so, do you have any physiotheraphy programme you wish us to support with you? Yes / No
Medical Referral Required? Yes / No **Details of Doctor:**	**Medical Clearance Received** Yes / No **Date Received:**
Tell us about any past injuries: 	NOTES

YOUR WELL-BEING

How do you feel on a daily basis:			
Energy	High	Med	Low
Health	High	Med	Low
Fitness	High	Med	Low
Strength	High	Med	Low
How do you feel about your health, body, diet at the moment?			
How would you like to feel about your health, body and diet in the future?			

YOUR PERFORMANCE MEASUREMENTS

Resting heart rate			Subscapular		
Resting BP			Waist		
Sit & Reach Flexibility			Hip		
Chest			Thigh	Left	Right
Upper arm	Left	Right	Bicep	Left	Right
Tricep	Left	Right	Iliac crest		
Calf	Left	Right	Are you currently exercising?		