HEALTH & FITNESS

healthy bodies - healthy minds - healthy lives

CLIENT INFORMATION

YOUR DETAILS	
Full Name:	Birth Date:
Address:	
Contact Numbers:	
Email Address:	Emergency Contact Name & No.

YOUR GOALS	
How can we increase your quality of life: ☐ I need to get fitter ☐ I need to look my absolute best ☐ I need more muscle tone ☐ I need to improve my self confidence ☐ I need to build muscle ☐ I want to lose weight ☐ I want to maintain my fitness level	☐ I need to get stronger ☐ I want to feel good about my body ☐ I need more energy ☐ I have a specific sporting goal ☐ I need a healthy eating plan ☐ I need to rehabilitate part of my body (which part?) _____
Do you have a specific goal you wish to achieve? If so, what is it?	
Why is it important to you to achieve these goals?	
If you have a goal, when would you have liked to achieve it by?	
How would you feel if you achieved your goal?	
How would you feel if you did not achieve your goal?	
If you continue your current lifestyle or repeat previous exercise / eating habits will you be able to attain your goals?	
How many days per week are you able to commit to your exercise programme and for how long?	
At what time of the day can you commit your health and fitness programme?	Mornings / Afternoons / Evening and at what time?
What's your exercise style? ☐ Self Motivated ☐ Prefer to exercise with a partner	☐ Require regular help ☐ May lose motivation ☐ Need constant assistance

YOUR HEALTH	
Do you have any medical conditions that may prevent you from exercising?	Yes / No
If yes, please describe them:	

Have you ever had or have:

A heart attack	Yes / No
Heart surgery	Yes / No
A pacemaker	Yes / No
Heart failure	Yes / No
Heart valve disease	Yes / No
A heart transplant	Yes / No
Congenital heart disease	Yes / No
Musculoskeletal problems	Yes / No

Symptoms

Chest discomfort with exertion	Yes / No
Unreasonable breathlessness	Yes / No
Dizziness, fainting, blackouts	Yes / No

Other health items - do you

Take prescription medications	Yes / No
Take heart medications	Yes / No
Are pregnant	Yes / No
Trying to conceive	Yes / No
Any food/drug/medication allergies	Yes / No

If you answered Yes please explain _____

(if you marked yes to any of these questions you may have to visit a doctor prior to commencing an exercise programme)