Client Questionnaire

About You

Name	Surname			
Preferred name	Age	DOB	Sex	
Postal Address				
Email	Mobile			
Emergency contact	Relationship to you			
Mobile				

Your Work

Current role	Time spent per week
Phsical tasks/common movements required by your role/s?	

Your Health and Fitness Goals

I've chosen to personally train because I want... (mark all applicable)			
Bettter health	More strength	To be fitter	To be bigger (more muscle)
To be more toned	Greater flexibility	Improved clarity/mindfull-ness	More time for myself
More energy/vitality	Use it don't lose it/retain independance	Better balance	Mange stress better
Lose/maintain weight	Prepare for specific event (please specify)		
Please highlight the goals listed above which are of most importance to you.			

Exercise History

How often have you engaged in physical activity in the last 6 months?					
Never	1-3x Per week	4-5x Per week	5+ Per week		
Duration of physical activity?					
Up to 30mins	30-60 mins	60-90 mins	90+ mins		
Level of daily physical activity?		Low	Medium	High	

Do you have any active hobbies? Please specify)			
What activity/ies do you enjoy? (mark all that apply)			
Indoor	Outdoor	Group sport/classes/activities	
Hiking	Boxing	Interval training	Weight lifting/gym equip-ment
Aerobic/circuit work		Yoga/pilates/mat work/other	

Any activities you dislike?				
Have you ever had a regular fitness routine or played in group sport? (please specify)				
Yes	No			
Do you have fitness equipment at home?		No	Yes (Please specify)	

Your Lifestyle

Achieving your goals is not just about the exercise you do but also about incorporating this with many other aspects of your life. The following helps to determine the impact these areas will have on your success. On a scale of 1 - 10 (1=least and 10=greatest)					
How healthy do you feel?	How strong do you feel?	How energetic do you feel?	How fit do you feel?		
What time do you usually go to bed and what time do you wake?		Retire	Awaken		
In general, I feel that I sleep	Very well	Well	OK	Poorly	Very Poorly
On a scale of 1-10 (1=least and 10=greatest), please rate the amount of stress you experience:					
In your role/at work		In your personal life			

Lifestyle (cont.)

How much of the following do you drink each week?					
Coffee (cups)	Alcohol (std drinks)	Soft/fizzy drinks (glasses)		Water (glasses)	
I consider my diet is	Excellent	Good	Average	Poor	Very Poor
How many meals do you eat per day?					
What tends to be your largest meal of the day?		Breakfast	Lunch	Dinner	Other
What is a typical menu for your two (2) largest meals of the day?					
How many times per week do you eat out or have takeaway?					times
Have you ever dieted to lose weight? (please specify the weight loss regimes you've followed)				Yes	No
Are you on a special diet now? (e.g. vegetarian, gluten-free, etc.)		No	Yes (please specify)		
Have you ever seen a nutritionist, dietician or food coach?		No	Yes (please specify)		

Your Health

Do you have any of the following medical conditions?			
Type 1 diabetes	Type 2 diabetes	Stomach ulcer	Hernia
Cramps	Epilepsy	Asthma	Chronic Cough/Pneumonia
Back Pain/Injury/Osteoporosis		Arthritis/Joint or Muscular Pain/Gout	
Breathing Difficulty/Shortness of Breath		Dizzy Spells/Lightheadedness/Seeing Spots	
Please indicate if any of the following apply			
Chest pain/tightness		Heart/stroke condition	
Circulatory problems		Post- menopausal	
Male, age >45yrs	Female age >55yrs	History of high blood pressure	
History of high cholesterol	High cholesterol currently	Current blood pressure >140/90	
Family history of heart disease		Liver/thyroid/kidney condition	

Your Health (cont.)

Ever had a medical consultation regarding your heart?	
No	Yes (please specify)
When exercising, do you experience: chest discomfort, dizziness, breathlessness, fainting, joint discomfort or back pain?	
No	Yes (please specify)
Do you take any prescription medication/s? (please specify all prescriptions and how long you've been taking each)	
No	Yes (please specify)

Could you be pregnant?	No	Yes	Are you trying to conceive	No	Yes
Are you a smoker	No	Yes			

Are there any additional special conditions, previous injuries or other factors that may be relevant to your training that we haven't asked you about?
Are there any other special conditions, previous injuries or other factors relevant to your training that you feel may be relevant to mention?

Release

I acknowledge that participating in this physical activity is done at my own risk. I accept all risks and release the trainer from any liability associated with my participation in this physical activity. I acknowledge that participating in this physical activity may involve a risk of injury. I attest to being physically capable of participating in physical activity and a qualified medical practitioner has not advised me otherwise. I am not aware of any medical condition, injury or impairment that will be detrimental to my health if I participate in this physical activity. I will advise my trainer immediately if I become aware of any medical condition, injury or impairment in the future.

I certify that I am 18 years or older, have read and fully understand this document. Or, as parent/guardian, I agree to the above for myself and on behalf of the participant.

I agree to pay all fees as and when due and adhere to the cancellation policy which is that any cancellations within 24 hours of the time of the session will be charged and forfeited.

Client Signature	Date
Parent/Guardian Signature (if under 18)	Date