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Exercise and Health Status Questionnaire

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Please complete this questionnaire and bring it with you to your consultation.

Section 1 – Your Personal Details

Name	_____		
Address	_____		

		Post Code	_____
Telephone	Home	_____	Work _____
	Mobile	_____	
E-mail	_____		
Occupation	_____		
Date of Birth	_____		

Section 2 – Emergency Contact Details

Name	_____		
Address	_____		

		Post Code	_____
Telephone	Home	_____	Work _____
	Mobile	_____	

Section 3 – Your Doctor's Details

Name	_____		
Address	_____		

		Post Code	_____
Telephone	_____		

Section 4 – About Your Health Goals

1 What health goals would you like to achieve in the next 3 months?

2 What long term health goals would you like to achieve over the next 12 months?

3 Name 3 things you will do in order to improve your health.

Section 5 – About Your Exercise Habits

4 What are your main reasons for starting a fitness programme?

- | | |
|---|---|
| <input type="checkbox"/> General conditioning | <input type="checkbox"/> Weight/fat loss |
| <input type="checkbox"/> Stress management | <input type="checkbox"/> Muscular strength |
| <input type="checkbox"/> Aerobic fitness | <input type="checkbox"/> Flexibility |
| <input type="checkbox"/> Enjoyment | <input type="checkbox"/> Social |
| <input type="checkbox"/> Improve self esteem | <input type="checkbox"/> Disease prevention |
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Other _____ |

5 How would you describe your fitness condition in terms of your general health and fitness?

6 Have you ever done any structured exercise? Yes No

If you answered No, please go to question 12.

7 What was it?

8 How many times a week did you exercise? _____ days per week

9 How long did you stick with it?

10 Did you get the results you wanted? Yes No

If you answered No, please go to question 12.

11 If you did, why did you stop?

12 What activity do you enjoy doing the most?

13 What do you like doing the least?

14 What would you identify as the main barriers preventing you from exercising in the future?

- | | |
|--|---|
| <input type="checkbox"/> Procrastination | <input type="checkbox"/> Lack of motivation |
| <input type="checkbox"/> No time | <input type="checkbox"/> Lack of facilities |
| <input type="checkbox"/> Injury | <input type="checkbox"/> Lack of ability/fitness |
| <input type="checkbox"/> Financial cost | <input type="checkbox"/> Lack of relevant knowledge |
| <input type="checkbox"/> Family responsibilities | <input type="checkbox"/> Medical advice |

Section 6 – About Your Nutritional Needs

15 On a scale of 1 – 10 (1 being very low quality, 10 being very high quality), how would you assess the quality of your diet? _____

16 Do you follow any particular diet? *Please tick all boxes that apply.*

- | | |
|--|--|
| <input type="checkbox"/> Vegetarian and fish | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Allergy elimination |
| <input type="checkbox"/> Other _____ | |

17 Would you like any advice or support to help you make any changes to the quality of your diet? Yes No

18 If you answered Yes, please give details of your 3 key goals.

- i) _____
- ii) _____
- iii) _____

19 Have you had your diet analysed before? Yes No

If Yes, when?

20 What choices do you normally make (please circle)?

Milk - Skimmed Semi-skimmed Full fat
Butter or Margarine
Fry or Grill
Bread type - White Brown Wholegrain Granary Other _____

21 Please list any mineral supplements.

Section 7 – About Your Lifestyle

22 How many units of alcohol do you drink in a typical week? _____

One unit of alcohol equals : - ½ pint of a standard beer/lager
1 small glass of wine
1 pub measure of a short

23 Do you smoke? Yes No

If you answered No, please go to section 8.

24 Indicate the number smoked per day.

1 - 9 10 - 19 20 - 39 40+

25 Do you want to stop smoking? Yes No

Section 8 – About Your Structural Health

26 Do you have any of the following conditions? Please tick all boxes that apply.

- | | |
|---|--|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Shoulder injury |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Head/neck injury |
| <input type="checkbox"/> Knee/thigh injury | <input type="checkbox"/> Arm/elbow injury |
| <input type="checkbox"/> Back pain/injury | <input type="checkbox"/> Hip/pelvis injury |
| <input type="checkbox"/> Wrist/hand injury | <input type="checkbox"/> Nerve damage |
| <input type="checkbox"/> Ankle/foot injury | <input type="checkbox"/> Bone fracture |
| <input type="checkbox"/> Swollen joints | |

27 If you answered Yes, please give details.

28 Are these or any other injuries aggravated by exercise? Yes No

If you answered No, please go to question 27.

29 If you answered Yes, please give details.

30 Are you presently receiving physical therapy? Yes No

Section 9 – About Your Medical History (based on your answers in this section we may ask your permission to seek your GP's advice before commencement of any exercise programme)

31 Is there a family history of any of the following medical conditions?

- | | |
|---|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Early menopause |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other medical conditions |

If Other, please give details.

For office use only – to be completed by your trainer

GP to be contacted? Yes / No

If yes

Date letter sent _____ Letter ref _____

Date GP response received _____

32 Have you had major surgery in the last 10 years? Yes No

If Yes, please give details.

33 Have you had minor surgery in the last 2 years? Yes No

If Yes, please give details.

34 Please tick any of the following for which you have been diagnosed or treated by a physician or health professional.

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart problem |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Other | |

If Other, please give details.

35 Tick all medicine taken in the last 6 months.

- | | |
|--|---|
| <input type="checkbox"/> Blood thinner | <input type="checkbox"/> Diabetic medication |
| <input type="checkbox"/> Epilepsy medication | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> Beta blockers | <input type="checkbox"/> Other medication which might affect exercise |

If Other, please give details.

36 Tick the box if you ever experience any of the following symptoms. Do you

- ever get unusually short of breath with very light exertion?
- ever have pain, pressure heaviness or tightness in the chest area?
- regularly have unexplained pain in the abdomen, shoulder or arm?
- ever have severe dizzy spells or episodes of fainting?
- regularly get lower leg pain during walking that is relieved by rest?
- ever feel "skips", palpitations or runs of fast beats in your chest?

37 Please list any health problems you suffer from, not already mentioned.

38 Are you currently pregnant or have you given birth in the last 12 months?

Yes No

Declaration:-

I confirm that to the best of my knowledge the information given within this document is correct, and understand that it will be treated with strictest confidence by _____ (and by those acting for and on behalf of _____ for services that I may wish to engage in now and in the future.

Signature : _____

Date : _____

Client – Trainer Agreement

- The trainer will use their skills and knowledge to design a safe programme of exercise that will take into account the personal goals, fitness levels and exercise likes and dislikes of the client.
- The trainer will provide the coaching, supervision advice and support that the client may need to help them achieve their goals. The client's progress will be regularly monitored and the programme revised and adjusted accordingly.
- The trainer will provide all necessary equipment for all training sessions.
- All client information will be kept strictly private and confidential. If the trainer requires further medical information from a practitioner, the client must provide such details.
- It is understood that the client and trainer will both commit to the programme and give 100% effort.
- The Client and trainer are required to arrive 5 minutes prior to a training session so that the session can be achieved on each visit.
- The client is required to wear appropriate clothing and footwear. Clothes should be loose fitting and not restrictive. Footwear should be comfortable and provide adequate support.

Personal Training Terms and Conditions

Health Screening

- All clients must complete a PAR-Q before commencing any exercise programme
- Your trainer may require a letter of "medical clearance" from your GP. Please be aware that your GP may charge you for this.

Cancellation Policy

- 24 hours notice is required for all appointments.
- Session cancelled less than 24 hours will be charged in full

Lateness Policy

- If the client is late for a session the session will not be extended and will end at the appointed time.
- If the trainer is late, additional time will be added to the session or to subsequent sessions.

Fee Charging policy

- Block bookings must be paid for in advance BUT sessions do not need to be booking in advance. However, all sessions must be redeemed within 90 days.
- All monies paid are non-refundable

I recognise and understand all the terms and conditions set between my personal trainer and myself and agree to follow all the guidelines set out above.

Client sign : _____

Print name : _____

Date : _____

Trainer Sign: _____

Print Sign : _____

Date : _____