Client Health Questionnaire

FITNESS ACADEMY

Train Smarter, Not Longer

Client Details

Title: (delete as applicable) Mr Mrs Miss Ms Dr Other
Name:
Surname:
Date of birth:
Age:
Gender: (delete as applicable) Male Female
Address:
Phone:
Mobile:
Email:
Emergency contact number:

Lifestyle & Goals

Rate how important the following is to you (delete as applicable) 1 is lowest, 10 is highest

Improve overall health (including reducing blood pressure and cholesteral level)									
1	2	3	4	5	6	7	8	9	10

Improve cardiovascular fitness									
1	2	3	4	5	6	7	8	9	10

Reshape or tone my body									
1	2	3	4	5	6	7	8	9	10

Improve performance for a particular sport									
1	2	3	4	5	6	7	8	9	10
Which sport?									

Improve moods and ability to cope with stress									
1	2	3	4	5	6	7	8	9	10

Improve strength									
1	2	3	4	5	6	7	8	9	10

Improve flexibility									
1	2	3	4	5	6	7	8	9	10

Increased energy levels									
1	2	3	4	5	6	7	8	9	10

Enjoyment									
1	2	3	4	5	6	7	8	9	10

How much time do you have to exercise?
Minutes per session:
Days per week:
What is your key goal or outcome?
Why are you acting on this goal now?
Divide your goals into short, medium and long term and state what you want to achieve: Short term (10-12 weeks): Medium term (13-51 weeks): Long term (52 weeks +):

Physical Activity

In the last year how often have you participated in exercise? (delete as applicable)			
3-4 times per week	1-2 times per week	1-2 times per month	Not really at all
What exercise has worked for you in the past?			
What types of exercise or physical activity do you enjoy?			
If you have been unable to exercise regularly, what are the reasons?			

How would you rate your overall level of fitness?									
1	2	3	4	5	6	7	8	9	10

How would you rate your aerobic fitness?									
1	2	3	4	5	6	7	8	9	10

How would you rate your current strength endurance?									
1	2	3	4	5	6	7	8	9	10

How flexible are you?									
1	2	3	4	5	6	7	8	9	10

How coordinated are you?									
1	2	3	4	5	6	7	8	9	10

Nutrition

(delete as applicable)

Do you think you follow a healthy diet? All of the time Some of the time Never
How many meals and snacks do you have a day? Less than 3 3-4 More than 4 Other
Do you think you eat too much? All of the time Some of the time Never
What do you think your daily calorie intake is? Less than 2,000 calories Between 2,000-3,000 calories More than 3,000 calories

Occupation

What is your present employment?
Does your role involve much physical activity? If so what?
How many hours do you work per day?
How many days per week?
What is your usual work pattern? (Day shifts/night shifts)
When are your usual days off?
How do you travel to work?
How long do you spend travelling?

There are many benefits of taking part in physical activity; however it is important to screen each individual to ensure we have a full background of your medical history prior to taking part in any exercise programme. If we feel it

necessary, we may refer you to your doctor to confirm they are happy for you to exercise, prior to starting your programme.

YOUR INSTRUCTOR WILL TREAT ALL INFORMATION CONFIDENTIALLY.

All answers need to be true and as accurate as possible. It is important these answers are honest as this will affect your ability to perform exercise and will allow your instructor to develop a safe and appropriate exercise plan.

Medical Screening

(delete as applicable)

Has your doctor ever said that you have a heart condition or that you should only do physical exercise recommended by a doctor? Yes No If yes, please give details:	
Have you ever had a heart surgery procedure? Yes No If yes, please give details:	
Do you ever feel pain in your chest? a) During rest: Yes No (If yes, please see your doctor for a referral) b) During physical activity: Yes No	c) During exercise: Yes No If yes, please give details:
Do you ever experience: a) Dizziness: Yes No b) Fainting: Yes No c) Blackouts: Yes No	d) Shortness of breath: Yes No If yes, please give details:
Are you currently taking any of the following medication? a) Prescription: Yes No If yes, please give details:	b) Over the counter: Yes No If yes, please give details:
Do you have epilepsy: Yes No If yes, do you take medication: Yes No When was your last attack?	**Are you unused to exercise:** Yes No Are you unused to activity: Yes No
Do you have Type 1 Diabetes? Yes No If yes, is it controlled? Yes No	Do you have Type 2 Diabetes? Yes No
Do you smoke or have you smoked in the last 6 months? Yes No If yes, how many days? How many years have you smoked?	
Are you aware of any other condition which may prevent you from exercising without any medical release forms from your doctor? Yes No	
Do you have asthma or any other lung condition? Yes No If yes, please give details:	
Have you had any of the following surgery? a) Bones or joints: Yes No b) Heart or brain: Yes No c) Other organ: Yes No d) Cosmetic: Yes No	e) Any surgery in the last 12 months: Yes No If yes, please give details:
Are you pregnant/been pregnant or given birth in the last 6 months? Yes No	

Do you have any muscle/joint/bone problems? Yes No If yes, please give details:

Pelvic Floor Health (all woman)

Have you recently or ever had a baby? Yes No If so please give details of type of birth eg caesarean, vaginal, forceps etc
Do you experience any difficulty in controlling urine when you cough, sneeze, laugh or jump or leak without warning? Yes No
Do you experience any difficulty in controlling your bowel, wind or urinary urges? Yes No
Do you experience any discomfort or pressure into your vagina or back passage? Yes No
Have you ever been diagnosed with a prolapse or think you may have one? Yes No
Do you have difficulty inserting or using tampons? Yes No
Do you experience pain during intercourse? Yes No
Do you have a gap between your tummy muscles? Yes No

If you have answered yes to any of the above or have a history of pelvic pain, constipation, endometriosis, recurrent cystitis, menopausal symptoms, gynaecological surgery and /or are concerned about your bladder or bowel function then you may benefit from seeing our women's health physiotherapist, Gemma Pilkington.

Your Baby

If you have given birth in the last 12 months please answer the following questions:

Date baby was born:
Type of delivery: Natural C-Section
Did you have an episotomy?: Yes No
Are you breastfeeding?: Yes No
Were there any complications during your **pregnancy or childbirth?:** Yes No If yes, please explain:
Has your doctor given you the all clear to exercise?: Yes No

Your Pregnancy

If you are pregnant please answer the following questions:

Has your doctor or midwife advised you against doing physical activity or exercise?: Yes No
Have you been participating in regular physical activity of a similar type being proposed prior to becoming pregnant?: Yes No

Have you experienced any of the following?: (delete as applicable) Shortness of breath Gestational diabetes Hypoglycaemia Miscarraige Multiple births Pelvic/Abdominal cramp Vaginal bleeding Imcompetant cervix
Is there anything in your medical history that you feel could affect your ability to exercise during pregnancy?:
Is there anything about your pregnancy or birth you feel is relevant to your participation in an exercise program?:
What concerns you most about pregnancy, birth or the post-natal phase?:
We recommend you reduce the intensity of your exercise to a moderate level, do you understand the meaning of this and agree to limit your efforts accordingly?: Yes No

Terms & Conditions:

All clients must agree to the Terms and Conditions as stated below prior to taking part in any group exercise classes or personal training sessions.

We reserve the rights to change the Terms and Conditions at any time. These changes will be clearly communicated to all clients.

Health & Safety
- All clients must complete a 'Medical Screening' questionnaire and declare all information accurately and honestly prior to commencing any form of exercise.
- Any client with a condition which requires any form of medical checks or prescription medication must have the consent of their doctor before engaging in any exercise sessions.
– Clients are responsible for monitoring their own condition whilst engaging in exercise and any unusual symptoms must be reported to their instructor immediately.

Liability
- Clients attending classes or personal training sessions are taking part entirely of their own risk.
– Clients must accept that whilst engaging in exercise of any kind, be it cardio, resistance, stretching or core exercises, there is a risk of injury and The Fitness Academy (including The Little Fitness Academy) shall not be held responsible for any injury, accident, illness or loss (including indirect and consequential loss) caused or suffered by clients.
– During classes where babies and young children are present, it is the responsibility of the parent present to keep the child safe and free from danger. Any injury caused to the child on the premises or during a class is not the responsibility of The Fitness Academy, The Little Fitness Academy or any instructor working for them.
– Clients are responsible for their own insurance in respect of injuries suffered, loss of damage to equipment or personal belongings.
– Nothing in these terms and conditions limits or excludes The Fitness Academy and The Little Fitness Academy for death or personal injury resulting from its negligence or that of it's employees or agents.

I agree to the terms and conditions above.

Name:
Signature:
Date: