

Section 1 – Your Personal Details

Name _____

Address _____

Post Code _____

Home Tel _____ Work Tel _____ E-mail _____

Occupation _____ Date of Birth _____

Section 2 – Emergency Contact Details

Name _____

Address _____

Post Code _____

Home Tel _____

Work Tel _____

Section 3 – Your Doctor's Details

Name _____

Address _____

Post Code _____

Tel _____

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:

- | | | | | | |
|----------------------|--------------------------|------------------|--------------------------|---------------------|--------------------------|
| 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 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?

- | | | | | | |
|--------------------|--------------------------|----------------------------|--------------------------|--------------------------|--------------------------|
| 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 | <input type="checkbox"/> | | | | |

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?

1 2 3 4 5 6 7 8 9 10

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

- | | | | | | |
|---------------------|--------------------------|-------------------|--------------------------|-------|--------------------------|
| Whole food | <input type="checkbox"/> | Vegetarian & fish | <input type="checkbox"/> | Vegan | <input type="checkbox"/> |
| Allergy elimination | <input type="checkbox"/> | Vegetarian | <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

Section 7 – About Your Lifestyle

One Unit of Alcohol equals = 1/2 pint of a standard beer/ lager, 1 small glass of wine, 1 pub measure of a shot.

19. How many units of alcohol do you drink in a typical week?

20. Do you smoke? Yes No *If you answered No please go to Section 8*

21. Indicate the number smoked per day: 1–9 10–19 20–39 40+

22. Do you want to stop smoking? Yes No

Section 8 – About Your Structural Health

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

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"/>	Back pain/ injury	<input type="checkbox"/>
Arm/ elbow injury	<input type="checkbox"/>	Wrist/ hand injury	<input type="checkbox"/>	Hip/ pelvis injury	<input type="checkbox"/>
Ankle/ foot injury	<input type="checkbox"/>	Nerve damage	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>
Bone fracture	<input type="checkbox"/>				

24. If you have answered Yes, please give details.

25. Are these or any other injuries aggravated by exercise? Yes No *If you answered No please go to question 27*

26. If you have answered Yes, please give details.

27. Are you presently receiving physical therapy? Yes No

Section 9 – About your Medical History

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

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	<input type="checkbox"/>				

If other, please give details

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

If Yes, please give details

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

If Yes, please give details

Section 10 – Fitness test results

Date				
Height				
Weight				
Resting heart rate				
Blood pressure Sys/ Dias				
Skinfold				
Triceps				
Biceps				
Subscapular				
Suprailiac				
Total				
Body circumferential				
Neck				
Waist/ abdomen				
Hips				
Bio impedance				
Body fat %				
Lung function				
FEV1				
FVC				
FER				
PEFR				
Cardiovascular				
Activity				
Workload/ HR 1				
Workload/ HR 2				
Workload/ HR 3				
Activity				
Workload/ HR 1				
Workload/ HR 2				
Workload/ HR 3				
Strength & Endurance				
Exercise	Wt/Reps	Wt/Reps	Wt/Reps	Wt/Reps

Flexibility Notes
