# Client Questionnaire

**Name:** **DOB:** **Age:**

**Address:**

**Suburb:** **P/C:**

**Phone:**

**(Mob)** **Email:**

**Emergency Contact Name:**

**Phone:**

**How did you hear about ELEMENTS OF FITNESS?**

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## Medical History

**Doctor's Name:** **Phone:**

**Last Medical Check** (Date)**:**

**Are you taking medication?**

**If so please list all medication prescribed?**

**Have you suffered or are you suffering from?**

- Gout, Stroke, Diabetes, Epilepsy, Hernia
- Glandular or Rheumatic Fever
- Dizziness or Fainting
- Stomach/Duodenal Ulcer
- Liver or Kidney Condition
- Any Heart Conditions, Heart Murmurs, Palpitations or pains in chest
- High/Low Blood pressure
- High Cholesterol/Triglycerides
- Gynaecology conditions

**If yes to any of the above, please detail below:**

**Have you had or do you have?**

- Arthritis
- Asthma
- Cramps
- Muscular pain
- Any pain or major injuries in the areas of the Neck, Knees, Back, and/or Ankles

**If yes to any of the above, please detail below:**

| | |
|---|---|
| **Are you dieting or fasting?** | **Yes / No** |
| **Do you smoke?** | **Yes / No** |
| **Do you drink alcohol?** | **Yes / No** |
| **Is your job sedentary or physical?** | **Yes / No** |
| **Is there any condition that may limit any activities?** | **Yes / No** |
| **Is there any cultural consideration that needs to be informed?** | **Yes/ No** |

**If yes to any of the above, please detail below:**

**I, state that all information on this questionnaire is true and correct and acknowledge that I will not hold ELEMENTS OF FITNESS responsible for any illness, injury, or adverse change in medical condition arising directly or indirectly from any test, training, or rehabilitation carried out by ELEMENTS OF FITNESS.**

**Client's Signature: Date:**