Client Questionnaire

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

Address: _____

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

Phone: _____

(Mob) _____ **Email:** _____

Emergency Contact Name: _____

Phone: _____

How did you hear about ELEMENTS OF FITNESS?_____

Medical History

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

Last Medical Check (Date): _____

Are you taking medication?_____

If so please list all medication prescribed?_____

_____

Are you taking any vitamins or natural medicine?

_____

Have you suffered or are you suffering from?

- **Gout, Stroke, Diabetes, Epilepsy, Hernia**
- **Glandular or Rheumatic Fever**
- **Dizziness or Fainting**
- **Stomach/Duodenal Ulcer or any Digestive Disorders**
- **Liver or Kidney Condition**
- **Any Heart Conditions, Heart Murmurs, Palpitations or pains in chest**
- **High/Low Blood pressure**
- **High Cholesterol/Triglycerides**
- **Anxiety; Depression**
- **Vison or Hearing**
- **Asthma, Nasal or Lung conditions**

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

_____

_____

_____

_____

_____

Have you had or do you have?

- **Arthritis**
- **Joints**
- **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:

_____

_____

_____

_____

Nutrition

What do you typically eat for the following:
Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks

_____

Are you dieting or fasting? **Yes / No**

Do you smoke? If so how much per day?

_____

Do you drink alcohol? If so how much per day?

_____

How much water do you drink per day?

_____

How many caffeine containing products (coffee, tea, carbonated drinks) do you drink per day?

_____

Exercise

What is your daily activity level related to your occupation:

□ Sedentary i.e mostly sitting **□ somewhat active**
□ moderately active
□ very active (moving around or up most of the time)
□ heavy duty (lifting, moving thingd etc.)

What kind of physical activity level (exercise, sports) do you participate in. How often per week? How long each time?

_____

_____

Female Section ONLY!

Are you pregnant? Or trying to get pregnant? C- Section? **YES/NO**

Are you Perimenopause/Menopause/Postmenopause? **YES/NO**

Have you had or have any Gynaecology conditions? **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: _____