ONE 2 ONE
PERSONAL TRAINING
SPORTS MASSAGE THERAPY

Confidential Health and Lifestyle Questionnaire

NAME: ……**D.O.B:**……..
ADDRESS: ……..……..
……
TELEPHONE: (Home) …… **(Work)**…… **(Mobile)**…….....
E-MAIL: ……

Doctors Name:…….
Surgery Address:……..
……..
Telephone:……

In the case of emergency, whom may we contact?
Name:…… **Relationship:**……..
Telephone: ……..

Health Questionnaire

HAVE YOU EVER SUFFERED FROM OR CURRENTLY SUFFER FROM ANY OF THE FOLLOWING?

Asthma	**Y / N**	**Constipation**	**Y / N**	**Rheumatic Fever**	**Y / N**
Angina	**Y / N**	**Diabetes**	**Y / N**	**High Cholesterol**	**Y / N**
High Blood Pressure	**Y / N**	**Frequent Colds**	**Y / N**	**Palpitations**	**Y / N**
Low Blood Pressure	**Y / N**	**Dizziness/feinting**	**Y / N**	**Headaches**	**Y / N**
Epilepsy	**Y / N**	**Heart Disease**	**Y / N**	**Migraines**	**Y / N**
Arthritis	**Y / N**	**Shortness of breath**	**Y / N**	**Joint Pain**	**Y / N**

Details: ……
……..
……..
……..

Have any of your first degree relatives experienced the following conditions?

Heart Attack **Y / N** Heart Operation **Y / N** Congenital Heart Disease **Y / N** High Cholesterol **Y / N**

High Blood Pressure **Y / N** Diabetes **Y / N** Other Major illness ……

Have you ever had surgery? **YES** **NO** If yes, please give details
……
Have you broken any bones? **YES** **NO** If yes, please give details
……
Do you suffer from back pain? **YES** **NO** If yes, please give details
……
Do you have tension or soreness in a specific area? **YES** **NO** If yes, please give details
……
Do you experience numbness, tingling, or stabbing pains? **YES** **NO** If yes, please give details
……

Are you sensitive to touch or pressure in any area? **YES** **NO** If yes, please give details

……...

Do you experience stiff, swollen or painful joints? **YES** **NO** If yes, please give details

……...

What is your 'chief complaint'?

……..

What was the date of onset?

……...

What do you think may have caused the problem?

……...

Have you had any treatment for the condition to date?

……...

……...

Previous diagnoses.

……...

How does it affect you on a day-to-day basis?

……...

Are the symptoms brought on by certain activities?

……...

Do specific activities or positions alleviate your symptoms?

……...

When is the pain worse?

……...

Do you experience fatigue or lack of energy? Please give details.

……...

Have you had any of the following: physiotherapy, osteopathy, chiropractic treatment, massage therapy? Please give details.

……...

……...

Please list any medications that you are currently taking:

……...

Lifestyle Questionnaire

Occupation; please explain your position along with the physical and mental responsibilities involved.

……..

……..

……..

How do you feel about your job? (i.e. do you enjoy your work?)

……...

Do you have an ergonomically set up desk/workstation?

……...

How many hours do you spend in front of a computer per day?

……...

How do you travel to work?

……...

How much time do you spend in a seated position per day?

……...

On a scale of 1 to 10 (1=not active, 10=very active), please rate how active you are on a daily basis.

……...

How many hours sleep do you get each day?

……...

Do you consider yourself to be under any stress? If yes, please explain further.

……...

……...

Do you smoke? If yes, how many do you smoke per day?

……...

What leisure activities do you do and how many times a week do you do them?

……..

……..

……...

On a scale of 1-10 (10 being very active and 1 is sedentary), how active are you?

……...

Have you ever performed resistance training exercises before? (free weights, resistance machines etc). Please give details.

……..

……

Daily Dietary Intake

No. of cups of coffee: …….
No. of cups of tea: …….
Glasses of fizzy drinks: …….
Glasses of milk: …….
Glasses of water: …….
Portions of vegetables: …….

Amount of sugar (spoonfuls): ……...
No. of chocolates: ……...
No. of sweets: ……...
Alcohol (glasses/pints): ……...
Portions of fruit: ...……

Do you follow, or have you recently followed any specific dietary intake plan? If yes please give details.
……
……
……
How do you generally feel about your nutritional habits?
……
……

Goal Questionnaire

Please list THREE personal goals in their order of importance:

1. ……...
2. ……...
3. ……...

Where are you now in relation to your goals?
……
……

How much time are you willing to dedicate towards achieving these goals?
……

What is the biggest challenge that you must overcome in order to achieve your goal? (e.g. time, family, weight loss etc)
……
……

List three tasks that you can do daily, which you think will pave the path towards total achievement:

1. ……...
2. ……...
3. ……...

Have you ever had a personal trainer? If yes, please give details of when and for how long:
……
……
How did you find out about One 2 One?
……

All the information given on this form is to the best of my knowledge correct and accurate.

I understand that all the information given will be kept confidential.

Client's
Signature: ……..

Print
Name: ……..
Date: ……..

Register of Exercise Professionals