OptimalMe
Fit for Living

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Precautions:_____

Recommendations:_____

_____

Completed:_____

Health & Fitness Questionnaire

This format is approved and recommended by the NZ Register of Exercise Professionals

Thank you for taking the time to answer the following questions.
Your answers will help me determine the best approach to help you reach your goals.

Name	DOB
Home address	Home phone
	Work phone
Occupation	Cell phone
Email address	
In Case of Emergency	Phone numbers
Name	

How did you hear about us? (please circle)
Signage Newspaper Friend YellowPages Radio Flyer Website Other (specify)_____

Which of these health and fitness goals are important to you?

	Please tick	Why? Explain- describe. By when?
Cardio fitness / endurance		
Lose weight / body fat		
Tone / firm muscles		
Improve flexibility		
Improve core strength		
Build overall or specific muscle /strength		
Improve balance		
Injury rehab		
Chronic pain relief		
Manage stress		
Have more energy		
Sleep better		
Other (describe)		

Why now?

Are you presently exercising? (please circle YES or NO and answer BOTH columns if relevant)

YES →	NO →
What type of exercise?	Have you done any structured exercise in the past? Yes / No
How many times per week?	If yes, what was it?
How long have you been doing it?	How long ago? How many times per week?
Have you been consistent?	How long did you stick to it?
Are you getting the results you want?	Did you get the results you wanted?
If yes, what brings you here today?	If you did, why did you stop?
If no, describe the inadequacies of your program.	If not, what was needed to make it successful?

Medical background

Have you had treatment for any of the following?	No / Yes	Please give details
A heart condition		
Diabetes – Type I or II		
Arthritis		
Asthma		
High blood pressure		
High cholesterol		
Epilepsy		
Osteoporosis		
Endometriosis		
Do you have any injuries or issues with joints or muscles in the following areas? (please circle)	Ankles Knees Hips Back Shoulders Neck Elbows Wrists	
Do you experience bowel or bladder leakage or a feeling of downward pressure?		
Have you smoked in the last 5 years?		
Are you currently taking any medication? If so, what?		
Are you currently undergoing any other form of treatment or physical therapy?		
Have you had any operations?		
Do you have any other conditions that may affect your ability to exercise?		
Do you have doctor's clearance to exercise (if needed)?		

Lifestyle factors

	Please give details
What is your current occupation?	
Does your work or any other pastimes involve extended periods of sitting?	
Does your work or any other pastimes require extended periods of repetitive movements?	
Do you often wear high heels or dress shoes?	
On average how many hours sleep do you have on a daily basis? Do you feel rested when you wake?	
How much stress are you currently experiencing in your life in general (1 = not much at all, 5 = incredibly stressed)	

Dietary habits

	No / Yes	Please give details
Give an example of what you eat for breakfast.		
Give an example of what you eat for lunch.		
Give an example of what you eat for dinner.		
Do you have a morning and afternoon snack between meals? If yes, give an example of what you would eat.		
How much water do you drink daily?		
How much coffee or tea do you drink daily?		
How much alcohol do you drink daily/weekly?		
How much fizzy or sports drinks do you consumer daily/weekly?		
Do you take any supplements? If so, what and how many/much?		

Informed consent

☐ I hereby acknowledge that the information provided above regarding my health is, to the best of my knowledge, correct. I will inform you immediately if there are any changes to my health status.

Disclaimer

☐ I acknowledge that participating in physical activity carries a risk and I accept all responsibility for that risk.

Confidentiality

☐ I understand that all information provided in this questionnaire is confidential.

Client signature:_____ Trainer's signature:_____

Date:____/____/____ Date:____/____/____

REPs registered trainer