

The Fit Dimension

Client Questionnaire

Name Date of Birth.....

Address.....

Email Address

Phone (Home).....Business.....Mobile

Business NameOccupation.....

Emergency Contact

Phone (Home).....Business.....Mobile

Have you ever undertaken regular physical activity? Yes No

If yes, describe briefly?

When was your last medical check-up?

Are you taking any medication? Yes No

How did you hear about us?

HAVE YOU EVER SUFFERED FROM? (Please Tick)

	YES	NO	NOT SURE
Breathing difficulty/shortness of breath/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain / Tightness in the chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations / Heart irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart / Stroke Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells / Light Headed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough / Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Joint / Muscular Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Disclaimer

The client agrees that he/she has had a medical check up prior to the commencement of their training, and there are no medical or similar conditions that may affect your training. If there are any conditions it is vital that your trainer be made aware of them.

Signature Date.....