

## LIFESTYLE QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

### GOALS

Health & Fitness: y \ n

Muscle tone: y \ n

Reduce body fat: y \ n

Increase muscle mass: y \ n

Sports specific: y \ n

Have you been exercising regularly: y \ n

What type- \_\_\_\_\_

What Intensity: \_\_\_\_\_

Duration\Frequency: \_\_\_\_\_

### LIFESTYLE & MEDICAL CONSIDERATIONS

Are you taking medication that will affect your training: y \ n

If yes what type: \_\_\_\_\_

Are you injured: y \ n

If yes what is the injury: \_\_\_\_\_

Do you smoke: y \ n

Are you pregnant: y \ n

Asthma problems: y \ n

High blood pressure: y \ n

### DO YOU SUFFER FROM (or have you suffered from) THE FOLLOWING

Raised cholesterol: y \ n

Heart Condition: y \ n

Dizziness: y \ n

Fainting: y \ n

Hernia: y \ n

Stroke: y \ n

If you have answered yes to the above questions please consult your Doctor prior to commencing your training program.

I understand that an exercise program has certain risks. I take it upon myself to discuss any changes in my current health with my trainer\instructor. I have to the best of my knowledge provided accurate information regarding my current health status.

Signed \_\_\_\_\_ Date \_\_\_\_\_