* CONSULTATION QUESTIONNAIRE*

To help me assess your needs and requirements as well as design the most effective programme to help you achieve your goals, please complete this survey and return it to me before our consultation meeting.

|  |  |  |
| --- | --- | --- |
| ***Personal Details*** |  |  |
| Full Name |  |  |
| Male/Female |  |  |
| Date of Birth |  |  |
| Contact Details• Mobile• e-mail |  |  |
| Address |  |  |
| Height |  |  |
| Weight [Either stones & pounds or kilos] |  |  |
| ***Medical Matters*** |  |  |
| Have you ever had any serious illnesses/injuries or surgery? If yes, please provide details opposite |   |  |
| Do you have any current medical condition, illness or injury? If yes, please provide details opposite. |  |  |
| Are you taking any medication or receiving any treatment for the current medical condition, illness or injury? If yes, please provide details oppositeAre you taking any other medication, prescribed or otherwise?If yes, please provide details opposite  |  |  |
| When did you last have your blood pressure taken?Please state the reading if you can remember |  |  |
| Have you has a cholesterol test?Please state the result if you can remember |  |  |
| Are you pregnant? If yes, please provide details opposite [how far into term etc] |  |  |
| Have you recently had a child? If yes, please provide details opposite [date of delivery, natural/caesarean etc] |  |  |
| Do you have any muscles or joints that you think are;1. weak and/or
2. cause you any problems?

If yes, please provide details opposite. |  |  |
| ***Lifestyle Matters: Nutrition*** |  |  |
| Please list what you would eat in a typical day;1. Breakfast:2. Mid-morning snack:3. Lunch:4. Afternoon snack:5. Dinner:6. Supper:Any other times? |  |  |
| How do you feel 1-2 hours after eating a meal, e.g. full of energy, weary & tired, lacking in energy etc? |  |  |
| How much water do you drink per day (in glasses)? |  |  |
| How much tea or coffee do you drink per day (in cups) and is it decaffeinated? Please specify what types of tea or coffee |  |  |
| How much alcohol do you drink per week?• Glasses of wine• Pints of beer• Others |  |  |
| How many servings of fruit and vegetables do you eat per day?• Fruit: (a medium serving is e.g. 1 apple)• Vegetables: (a medium serving is 3 heaped tablespoons) |  |  |
| Do you regularly choose low fat options? |  |  |
| Are you a vegetarian or vegan? |  |  |
| Do you prefer white or wholemeal foods? |  |  |
| Do you buy organic foods? |  |  |
| What is your favourite food? |  |  |
| Do you eat chocolate, biscuits, cakes, sweets or crisps on a daily or weekly basis? If yes, please state which and quantities of each per day or week |  |  |
| What do you usually eat in the 2 hours before exercise (if anything)? |  |  |
| Do you know how many calories you consume each day? If yes, how many? |  |  |
| Do you take vitamin supplements?If yes, please describe. |  |  |
| ***Lifestyle Matters: Smoking*** |  |  |
| Do you smoke at all? If yes, how many cigarettes do you smoke per day? |  |  |
| ***Lifestyle Matters: Sleep*** |  |  |
| How many hours sleep per night do you have on average? |  |  |
| How long does it take you to fall to sleep each night? |  |  |
| Do you have trouble going to sleep often or occasionally? |  |  |
| Do you wake up in the night often or occasionally? |  |  |
| Do you sleep during the day and, if so, for how long? |  |  |
| Do you feel refreshed or tired in the mornings? |  |  |
| ***Lifestyle Matters: Exercise*** |  |  |
| How many days per week do you exercise (if any)? |  |  |
| Please specify what type of exercise and for how long is each session:• Gym• Exercise classes (specify which)• Outside (specify what)• Swimming pool* Team sports (specify which)

• Other (please specify) |  |  |
| Do you have a current gym programme? |  |  |
| When was it last reviewed? |  |  |
| Please provide a copy of the gym programme or list what exercises you do at the gym. | 1.2.3.4.5.6. |  |
| What are your favourite exercise activities? |  |  |
| Do you exercise because you want to or because you feel you should?  |  |  |
| What are the factors that stop or restrict you from exercising, if any, e.g. time, work, family commitments etc? |  |  |
| What is the most convenient time(s) of the day for you to exercise or train?What days are you not available? |  |  |
| What time of the day do you feel most energized for exercise or training? |  |  |
| ***Lifestyle Matters: Work*** |  |  |
| What job do you do? Please describe opposite. |  |  |
| Is it full or part time?If part time, how many days/hours per week? |  |  |
| Is it sedentary (mainly sitting down) or active? |  |  |
| If sedentary, how long do you spend sitting down per day (in hours)? |  |  |
| Does it involve a lot of computer use and do you look up, down or straight at your screen? |  |  |
| Is your chair at work supportive? |  |  |
| Do you suffer from back pain/ache? If yes, is it occasionally or regularly?If yes, is the pain at the top, middle or lower part of your back? |  |  |
| How close to home is your place of work (in miles)? |  |  |
| ***Training and Fitness Goals*** |  |  |
| How would you describe your own level of fitness?  |  |  |
| Would you describe yourself as self-motivated and committed to fitness? |  |  |
| Please explain why you are looking to engage the services of a Personal Trainer? |  |  |
| Are you looking to change;1. your body weight
2. your body fat percentage
3. your muscle mass
4. your strength
5. your aerobic fitness
6. anything else?

Please provide details opposite. |  |  |
| Are there any specific areas of your body in particular that you are looking to change or improve and, if so, what are you looking to achieve? |  |  |
| What are your short term training/fitness goals? [Short term is up to 6 weeks.]Please make the goals **SMART**I can help you fine tune your SMART goals! | **S**pecific:**M**easurable:**A**chievable:**R**ealistic:**T**imescale: |  |
| What are your medium term training/fitness goals [Medium term is up to 3 months]Please make the goals **SMART**I can help you fine tune your SMART goals! | **S**pecific:**M**easurable:**A**chievable:**R**ealistic:**T**imescale: |  |
| What are your long term training/fitness goals [Long term is up to 12 months]Please make the goals SMARTI can help you fine tune your SMART goals! | Specific:Measurable:Achievable:Realistic:Timescale: |  |
| Do you have any other goals, health related, lifestyle related, or otherwise? If yes, please list. |  |  |
| ***And Finally!...........*** |  |  |
| Is there anything else that we have not covered that you would like to discuss with me?Please state the subject matter or feel free to raise this during the consultation meeting. |  |  |
| How did you hear of me? |  |  |
| Would you be interested to receive further specialist advice on any of the following?1. Nutrition for Weight Management
2. Nutrition for Physical Performance
3. Running Technique
4. Adaption of training for specific medical conditions
5. Postural assessment

If so, please specify which.  |  |  |
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