LewesFit

PERSONAL TRAINING . NUTRITION . FATLOSS

Personal Details - Lewesfit Client Consultation Record

Date (1st Consultation) _____
Surname _____
First Name _____
Date of birth _____
Gender M / F Mr / Mrs / Miss / Ms
Address

_____

Home telephone _____
Mobile _____
Email _____
Next of Kin Contact Details _____

_____

How did you hear about Lewesfit?

Lifestyle Questionnaire

Do you smoke? _____
Do you drink alcohol? _____
No. of units p/week? _____
Do you consider yourself stressed? _____

Occupation _____

Hobbies/Interests _____

_____

_____

_____

Do you have broken sleep? _____
Sleep Hours per night?

Current Exercise? _____
Frequency? _____
Exercise Likes/Dislikes? _____

How do you rate your diet?

_____

Food Likes _____
Food Dislikes _____

Daily Cups of Coffee _____
Daily Cups of tea _____
Daily Fizzy Drinks _____
Glasses of water _____

_____

Vegetable Portions _____
Amount of sugar _____
Sweets/Chocolates _____
Fruit Portions _____

Any other dietary Information _____

_____

_____

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

Heart attack

Heart operation

Congenital heart disease High cholesterol

Have you ever had surgery? If yes, please give details.

Have you ever broken any bones? If yes give details.

Do you suffer from back pain? If yes give details.

Date of onset & duration

What incident do you feel may have caused the problem?

Treatment to date

Previous diagnoses

Do specific activities or positions alleviate your symptoms?

When is the pain worse?

Do you experience fatigue or lack of energy? If yes provide details.

Please list any medications you are currently taking.

3 Main Goals	1. _____ 2._____ 3._____
Specific Goals	1. _____ 2. _____ 3. _____
Time Devoted To Achieve These (hrs per week)	_____ _____ _____ _____
Challenges To Overcome	1._____ 2._____ 3._____ 4._____

In signing this document, I agree that I have read and understand the Lewesfit Privacy Policy at www.lewesfit.com

Signature:

Print Name:

Date:

Measurement Assessments - TO BE COMPLETED BY TRAINER IF APPROPRIATE. PLEASE LEAVE THIS SECTION BLANK. THANK-YOU.

	Height		Blood Pressure
	Chest	**Bicep**	**Waist**
Site			
Date			
	Hip	**Thigh**	**Weight**
Site			
Date			
Notes			