Date: _____ **Height:** _____ **Age:** _____

PHYZIQUE SINGAPORE

Health and Lifestyle Questionnaire

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with a physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly:

Personal Detail

Name : _____ D.O.B: _____

Address: _____

_____ Postal Code: _____

Contact No. Home: _____ Handphone: _____ Email: _____

Are you currently seeing any doctor? If yes, please provide detail

Doctors Name: _____ Tel: _____

Name of Hospital or Clinic: _____

Last Medical Check-up: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Contact No. Home: _____ Handphone: _____

Confidential Health Questionnaire

Have you or do you suffer from any of the following.

(Please tick & give details where applicable)

☐Asthma	☐Constipation	☐Rheumatic Fever
☐Angina	☐Diabetes	☐High Cholesterol
☐High Blood Pressure	☐Frequent Colds	☐Palpitations
☐Low Blood Pressure	☐Dizziness/fainting	☐Headaches
☐Epilepsy	☐Heart Disease	☐Migraines
☐Arthritis	☐Shortness of breath	☐Joint Pain

Details: _____

_____

Medical History

Is there a family history of any of the following medical conditions?

☐Heart Attack	☐Diabetes	☐Epilepsy	☐Cancer
☐Congenital Heart Disease	☐High Cholesterol	☐High Blood Pressure	☐Asthma

Have you ever had surgery? ☐YES ☐NO (if YES, give detail)

Have you ever broken any bones? ☐ YES ☐ NO (if YES, give detail)

Please list any injuries you've had in the past. i.e., broken bones, sprains, etc.

Do you suffer from back pain? ☐ YES ☐ NO (if YES, give detail)

Do you have tension or soreness in a specific area? ☐ YES ☐ NO (if YES, give detail)

Do you experience numbness, tingling or stabbing pains anywhere? ☐ YES ☐ NO (if YES, give detail)

Are you sensitive to touch/pressure in any area? ☐ YES ☐ NO (if YES, give detail)

Do you experience stiff, swollen or painful joints? ☐ YES ☐ NO (if YES, give detail)

Are these or any other injuries, aggravated by exercise? ☐ YES ☐ NO (if YES, give detail)

Do specific activities or positions alleviate your symptoms? ☐ YES ☐ NO (if YES, give detail)

When is the pain worse?

Do you experience fatigue or lack of energy? ☐ YES ☐ NO (if YES, give detail)

Indicate on the diagrams where you have been experiencing pain.

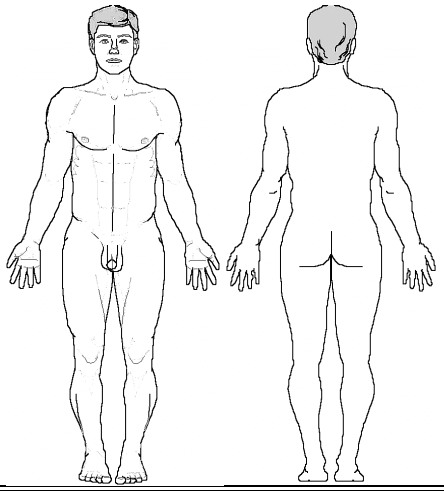
What is your current weight? _____ KG

Please list any medication you are currently taking.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____



Occupation: _____

How much time do you spend in a seated position?

On a scale of 1 to 10, please rate how active you are on a daily basis? (1 – not active, 10 – very active)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How many hours sleep do you get everyday?

Do you consider yourself to be under stress? If YES, provide details.

Are you currently involved in any exercise programme? If YES, please list duration and types of exercises.

How often do you take part in physical exercise?

☐ 7+ times/week ☐ 5-6 times/week ☐ 3-4 times/week ☐ 1-2 times/week

How long have you been consistently physically active for?

What activities are you presently involved in?

☐ Cardio/Sports Frequency: _____ per week

Average duration: _____ hour/ min

☐ Easy ☐ Moderate ☐ Hard

☐ Strength Training Frequency: _____ per week

Average duration: _____ hour / min

☐ Easy ☐ Moderate ☐ Hard

☐ Stretching Frequency: _____ per week

Average duration: _____ hour/ min

☐ Easy ☐ Moderate ☐ Hard

Do you smoke? ☐ YES ☐ NO (if YES, _____ stick per day?)

Do you drink alcohol? ☐ YES ☐ NO (if YES, _____ unit per week?)

Do you follow, or have you recently followed, any specific dietary intake plan, and in general how do you feel about your nutritional habits?

Do you have any food intolerances that you know of? ☐ YES ☐ NO (if YES, give detail)

Have you ever had a personal trainer? If yes provide details of when and for how long?

How did you find out about my services? Give details.

Food Diary Snapshot

Breakfast Time : _____ Snack Time: _____

Lunch Time : _____ Snack Time: _____

Dinner Time : _____ Snack Time: _____

Please list THREE goals in order of importance:

1. _____

2. _____

3. _____

How much time are you willing to devote toward achieving this goal?

_____

What is the biggest challenge you must overcome to attain your goal?

☐ Lack of interest/motivation ☐ Procrastination ☐ Lack of time

☐ Injury ☐ Lack of ability/fitness ☐ Lack of facilities

☐ Financial cost ☐ Family responsibility ☐ Medical Advice

☐ Low self-esteem ☐ Other, specify _____

On a scale of 1 to 10, please rate how committed you are to achieving your goal? (1 – not committed, 10 – very committed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

At Phyzique, we rely on word of mouth referrals. We believe that if we serve our clients well, they'll brag about us to everyone they know. So we're not shy about asking for referrals – we really do want to help your friends, family members and co-workers. Do you know people who could benefit from personal training or our other services and would appreciate information about our services? If so, please list their names and contact information below.

Name	Phone/E-mail
1. _____	_____
2. _____	_____
3. _____	_____

DECLARATION

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment.

I confirm that there has been no change in my health status since the completion of this questionnaire.

All information will be kept confidential.

Client's Signature: _____ Date: _____

LQ Reviewed on May 2014