

Client Information

About Yourself

Name _____ DOB _____
DD / MM / YY

Address _____
Postal Code _____

Home Tel () _____ Cell () _____

Business Tel () _____

email _____

In case of emergency who do I contact? _____

Relation _____ Tel _____

Health and Wellness Goals

- | | | |
|-----------------------------------------------|----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> lose weight | <input type="checkbox"/> improve flexibility | <input type="checkbox"/> reduce back pain |
| <input type="checkbox"/> feel better | <input type="checkbox"/> reduce stress | <input type="checkbox"/> improve diet |
| <input type="checkbox"/> aerobic fitness | <input type="checkbox"/> general fitness | <input type="checkbox"/> increase muscle size |
| <input type="checkbox"/> decrease muscle size | <input type="checkbox"/> increase strength | <input type="checkbox"/> move with ease |
| <input type="checkbox"/> sport specific | <input type="checkbox"/> look better | <input type="checkbox"/> injury rehabilitation |
| <input type="checkbox"/> other: _____ | | |

Do you currently have or previously had any conditions that may impact your ability to perform exercise? Please describe below.

Has your doctor or other therapist recommended you against exercising or certain exercises/movements?
