AMY VICTORIA Fit

Name: Surname: Gender:

Mobile: Email: DOB:

Height: Weight: Body Fat %:

Occupation: Activity Type:

Do you have a heart condition, high blood pressure or circulatory problems? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No Do you suffer from epilepsy? ☐ Yes ☐ No

Do you ever experience pain in your chest when exercising or at rest? ☐ Yes ☐ No

Do you ever feel faint or suffer from dizzy spells? ☐ Yes ☐ No

Do you have back pain or joint conditions that could be exacerbated by exercise? ☐ Yes ☐ No

Have you had any surgery in the past year that may affect your physical activity? ☐ Yes ☐ No

Are you aware of any other condition or injury that may give reason to modify your exercise programme? ☐ Yes ☐ No

Do you have asthma? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Approximately how many units per week:

Stress level
(1 = no stress at all) (10 = Very Stressed)

1 ○ 2 ◉ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Are you taking any medication?

Are you pregnant? Or have you given birth in the past 6 weeks?

Do you have any food/drink allergies?

Are you currently suffering from any injuries? Please specify below:

SIGN DATE