

CLIENT DETAILS

TITLE	FIRST NAME	SURNAME
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ADDRESS		

_____ POSTCODE		
DOB	AGE	GENDER (M/F)

HOME TEL:
BUS. TEL:
MOB. TEL:
FAX:
E-MAIL:



© PRE -EXERCISE QUESTIONNAIRE

All information obtained by FIT TOO TRAVEL is strictly confidential and will not be released to any person without your consent, unless in a life threatening situation.

Please read carefully and answer all questions honestly. For assistance with this form, call FIT TOO TRAVEL on 1300 36 88 52

HAVE YOU EVER EXPERIENCED, OR ARE YOU CURRENTLY EXPERIENCING...?

	Circle correct		Circle correct
Gout	YES / NO	Asthma, difficulty in breathing or chronic cough or other breathing disorder	YES / NO
Fainting attacks, Dizziness or light headedness	YES / NO	Any muscular or skeletal problem	YES / NO
Frequent muscular pain or cramps	YES / NO	Any Heart or Stroke Condition	YES / NO
Pain or tightness in the chest	YES / NO	Any liver or kidney condition	YES / NO
Stomach or Duodenal Ulcer	YES / NO	High Blood Pressure	YES / NO
High Triglycerides	YES / NO	High cholesterol	YES / NO
Rheumatic Fever	YES / NO	Epilepsy or fits	YES / NO
Diabetes	YES / NO	Hernia	YES / NO

EMERGENCY & MEDICAL INFORMATION

CONTACT IN CASE OF AN EMERGENCY	YOUR DOCTOR
TEL BH	TEL:
TEL AH	DATE OF LAST MEDICAL CHECK

FEMALES ONLY:

No. of children	<input type="text"/>	Date of last child's birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Are you pregnant now?	<input type="text"/> YES / NO	Could you be pregnant now?	<input type="text"/> YES / NO
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If you answered "YES" to any question above, for your own safety, you are required to provide a medical certificate before consultation with a FIT TOO TRAVEL Personal Fitness Trainer.

LIFESTYLE/EXERCISE HISTORY

What exercise, if any, do you regularly or occasionally do now?	
Are you on any prescribed medication? If yes, what?	Are you a smoker? If yes, how many cigarettes per day (maximum)?
Have you been in hospital in the last 12 months? If so, why?	
Have you ever had any injury, illness, joint or back condition that may be aggravated by vigorous exercise?	
Have you ever had any worrying symptoms, spells or experiences that may be aggravated by vigorous exercise?	
Are there any conditions, of any kind whatsoever, which may limit your level of activity? If yes, describe?	

CLIENT RESPONSIBILITIES/TERMS OF BUSINESS

I may change my Trainer at any time given a minimum of 24 hours notice, and/or may cancel my appointment at any time **up to** 24 hours prior to the appointment.

I understand that commitment is part of my training and accept that there is a 50% fee on cancellations with less than 24 hours up to six hours notice, and full fee if less than six hours notice of cancellation.

I understand that payment in advance is required to keep FIT TOO TRAVEL Personal Trainer costs low. I understand my FIT TOO TRAVEL trainer will only be available for appointments if payment is made prior to that appointment.

I understand that booking appointments with FIT TOO TRAVEL trainers is my authority to charge my credit card unless I expressly instruct FIT TOO TRAVEL otherwise.

I realise that participation in exercise carries some risk. I understand all the questions on this form and have answered them truthfully. I hereby certify that I am aware of no medical condition (except those already noted) that may increase my risk of illness or injury as a result of my participation in a regular exercise programme. I have read and understood this questionnaire and accept all risks associated with the undertaking of a fitness programme and hereby exempt, release and discharge Fit Too Travel and its employees, contractors, subcontractors or any associate companies for any injury, illness or adverse change in my medical condition or state of health arising directly or indirectly from any current or future training, rehabilitation or exercise programme recommended by or undertaken with Fit Too Travel and/or its employees, contractors, subcontractors or any associate companies.

TRAINER AND TRAINING PREFERENCES

Day /s of the week you want to train

Circle day/s
Mon Tue Wed
Thu Fri Sat Sun

Preferred gender of trainer

<input type="checkbox"/> MALE
<input type="checkbox"/> FEMALE
<input type="checkbox"/> BEST PERSON

What time of day is best for you?

How many days a week do you exercise now?

How many days a week do you want to see a trainer?

Signed

Date

