



Client Fitness Profile

Name: Date of Birth:
Surname First name Day Month Year

Address:
Number Street Suburb Postcode

Home ph: Work ph: Mobile ph:

Email address:

(please tick the box)

☞ Has your doctor advised you that your blood pressure is/was: High Low Normal

☞ Has your doctor advised you that your cholesterol is/was: High Low Normal

☞ Do you smoke: Yes No If yes, how many per day:

☞ Are you aware of any cardiovascular problems: Yes No

☞ If yes, please describe:

☞ Are you taking any medication: Yes No

☞ If yes, please describe:

☞ Do you have any known injuries or orthopaedic problems: Yes No

☞ If yes, please describe:

☞ Do you have any other medical problems that have not been mentioned ie: diabetes, asthma:

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☞ What are you short term goals within your program:

.....

.....

☞ What are you long term goals within your program:

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.....

Declaration

The above information is true to the best of my knowledge and if necessary I agree to supply a doctor's certificate before commencing any exercise program.

Client Signature

Romero Fitness Trainer

Client Nutritional Analysis

Please fill in the table below describing everything you consume in a typical day. Indicate as specific as possible the portion size and quantity.

MEAL TYPE	TIME	FOOD	DRINK
<i>Breakfast</i>			
<i>Morning Tea</i>			
<i>Lunch</i>			
<i>Afternoon Tea</i>			
<i>Dinner</i>			
<i>Snacks</i>			

Lifestyle

- ∞ How many standard drinks of alcohol would you consume per week:
- ∞ Are you allergic to any foods: Yes No
- ∞ If yes, please describe:
- ∞ List any foods you don't like:
-
- ∞ Foods you may crave:

Exercise

- ∞ Are you currently doing any exercise: Yes No
- ∞ If so, please describe:
- ∞ How many times a week:

It's Sensational!