

# 50 Plus Fitness – Personal Fitness

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www.50plusfitness.nz

Name \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address \_\_\_\_\_ Postcode \_\_\_\_\_

Tel. (H) \_\_\_\_\_ (W) \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_ (please write clearly)

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

What is you reason for wanting to Improve your fitness now? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current treatment – drugs, vitamin supplements, herbs, etc \_\_\_\_\_  
\_\_\_\_\_

## ***Symptoms*** – Please circle/highlight any symptoms experienced more than once a month

Indigestion/reflux	Neck/Shoulder pain	Anxiety
Bloating	Back pain	Allergic reactions
Constipation	Swollen/painful glands	Asthma
Cold hands/feet	Fatigue	Fainting / Dizziness
Skin problems	Frequent urination	Joint pain
Muscle pain/weakness	Females–Painful periods / PMT / Hot flushes / Absent periods	
Headaches	Nausea	Panic attacks

## ***Informed Consent***

*This is not a medical practice. I have been advised that Charlie Wong and any other practitioners are not medical practitioners and do not practice or prescribe allopathic medicine (medical drugs). Charlie is a personal trainer and exercise coach.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

How did you find out about us (please circle/ highlight)

Clinic sign      Local paper      Friend      Internet      Flyer      Other

P.T.O

Please complete questions as thoroughly as possible as it's a great help to plan your Fitness journey.

What is your current activity level.\_\_\_\_\_

Is there anything that may impact on you exercising.\_\_\_\_\_

What barriers ,if any do you think you have to getting fit? \_\_\_\_\_

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How long are you prepared to give to personal Training before you see a change?\_\_\_\_\_

Please give any additional information that you feel could be relevant and useful. It can be something small or even you may feel it's not really connected but you can share with me.-\_\_\_\_\_

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Rate the following conditions:\_\_\_\_\_

On a scale of 1- 10 how would you rate your diet? \_\_\_\_/10

On a scale of 1- 10 how would you rate your stress levels \_\_\_\_/10

On a scale of 1- 10 how would you rate your energy levels. \_\_\_\_/10

How much water do you consume each day? \_\_\_\_\_

How many hours of quality sleep do you get each night. \_\_\_\_\_