Get Gorgeous
Leaner, fitter, shapelier you

Client Information Sheet

PART 1: BASIC INFORMATION

Name:_____ Date: _____

Gender:_____ Age: _____

Date of Birth:_____ Height: _____

Weight:_____

Body fat percentage (Leave this for Module 1) _____

PART 2: BODY COMPOSITION

Please provide the following skinfold measures (in mm): (inches or centimeters).

Abdominal_____ Back_____

Triceps_____ Hipbone_____

Chest_____ Thigh_____

Under-arm_____

Please provide the following girth measurements

Neck_____ Chest _____

Shoulder_____ Biceps _____

Waist_____ Hips _____

Thigh_____ Calf _____

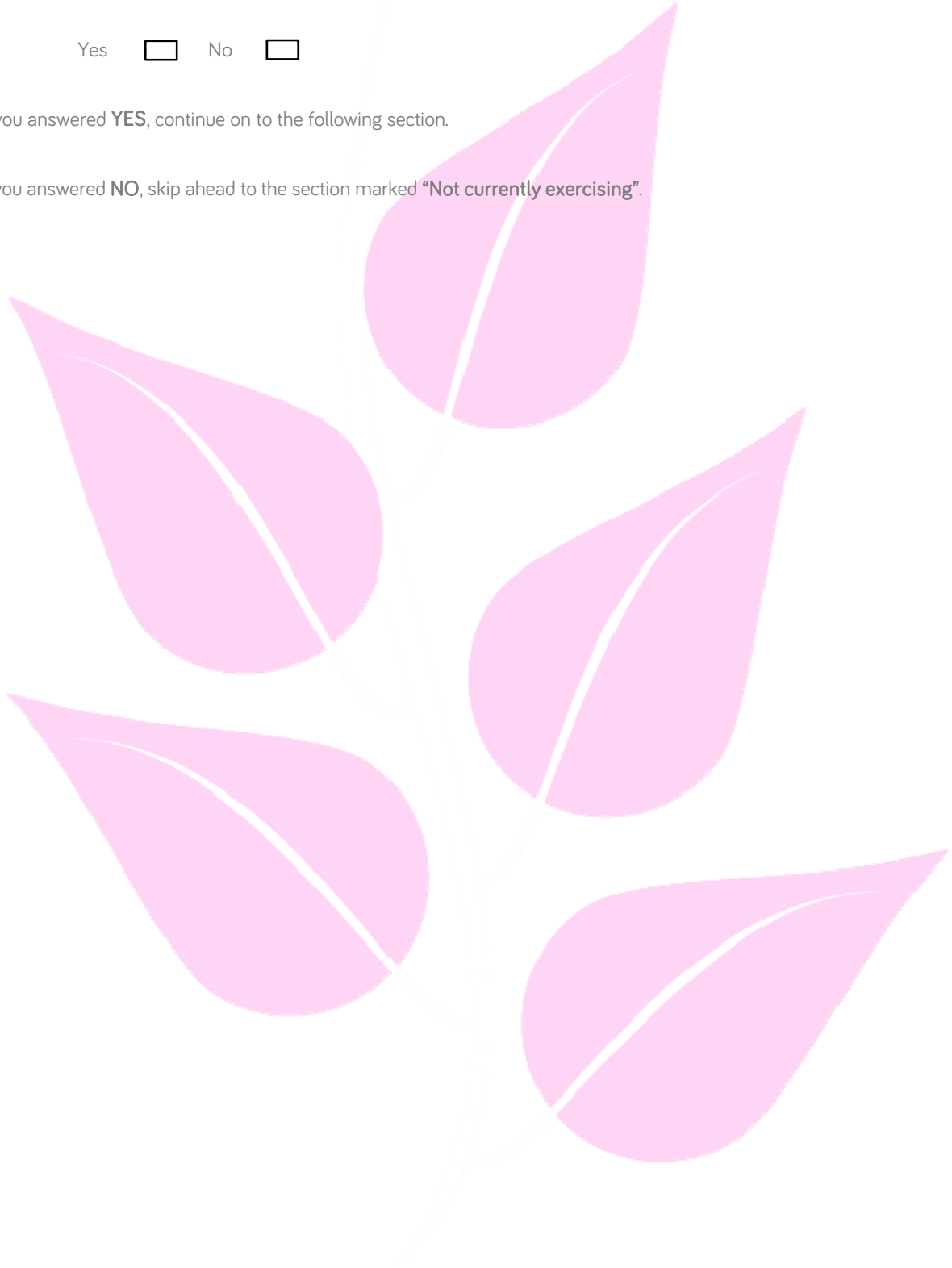
PART 3: EXERCISE INFORMATION

Are you currently exercising regularly (at least 3x per week)?

Yes ☐ No ☐

If you answered **YES**, continue on to the following section.

If you answered **NO**, skip ahead to the section marked **"Not currently exercising"**.



Complete this section if you ARE currently exercising regularly

How long have you been consistently exercising?

On the following chart, fill in which type of exercise you normally perform each day:

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Type of Exercise							

Fill in your approximate workout duration for each day (in minutes).

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Duration							

Complete this section if you ARE NOT currently exercising regularly

If you are not currently exercising regularly, have you ever been on a consistent exercise plan (at least 3x per week)?

Yes ☐ No ☐

If you have exercised on a consistent basis previously, how long ago was this and how long did it last?

PART 4: MEDICAL AND HEALTH INFORMATION

If you have any diagnosed health problems, list the condition(s). _____

If you are on any medications, please list them. _____

What additional therapies or interventions are being undertaken for the given health problem(s)?

If you have any injuries, please list them.

What additional therapies or interventions are being undertaken for the given injury(s)?

PART 5: LIFESTYLE INFORMATION

What do you do for a living? _____

What is the activity level at your job?

None (seated work only)" Moderate (light activity such as walking) ☐ High (very active) ☐

Does your job involve shift work?

Yes ☐ No ☐

If you follow a more regular schedule, do you work days, afternoons or nights? _____

Are you a primary caregiver for children, individuals with a disability, or an elder relative?

Yes ☐ No ☐

How often do you travel?

Rarely ☐ A few times a year ☐ A few times a month ☐

Weekly ☐

Please list the physical activities that you participate in outside of the gym and outside of work.

Please compile a brief timetable with your most normal daily schedule listing the time you wake up, work and have breaks, exercise and go to sleep:

How much money do you spend on groceries per month (provide amounts from your last two grocery bills)?

How many times per week do you shop for groceries?

How many meals do you eat in restaurants and/or fast food places per week?

Exactly how much money do you spend on supplements per month?

If you have any known food allergies, please list them below.

Are there any other foods to which you're particularly sensitive (i.e., which cause excessive gas, bloating, stuffiness, or congestion)?

If you're currently using any nutritional supplements, please list them (as well as the doses you're taking) below.

MISCELLANEOUS INFORMATION

If there is any other information you think might be relevant to your program design, please share it below.