Client Consultation Form

iUSP154 – Programming personal training with clients

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 ☐	20 – 30 ☐	30 – 40 ☐	40 – 50 ☐	50 – 60 ☐	60+ ☐
Lifestyle:	Active ☐			Sedentary ☐		
Last visit to the doctor:						
GP Address:						
Number of children: *(If applicable)*						
Date of last period: *(If applicable)*						

Contra-indications requiring medical permission – *in circumstances where medical permission cannot be obtained clients must give their informed consent in writing prior to treatment (Select if/where appropriate):*					
Any recent injuries including fractures, strains, sprains, ruptures or tears	☐	Any neurological disorders including strokes, multiple sclerosis unless medically supervised	☐	After a heavy meal or under the influence of alcohol	☐
Heart condition of any history of heart disease	☐	Any undiagnosed illness	☐	If over tired or exhausted	☐
High blood pressure unless medical permission has been granted	☐	Any musculoskeletal problems including joint or back pain	☐	If under the influence of painkilling drugs	☐
Any acute fevers including influenza, glandular fever or common cold etc.	☐	Any pain and soreness in muscles caused by trauma or injury	☐	If there has been any past difficulty with exercise in the past	☐
Any inflammatory joint conditions including arthritis, rheumatoid arthritis or osteoarthritis	☐	Pregnancy – medical permission must be sort before continuing	☐		

For people over the age of 50 a medical check-up should be sought before starting an exercise programme especially for the following – *(Select if/where appropriate):*					
Obese people	☐	Hypertensives	☐	Any history of lung problems including asthma, bronchitis or emphysema	☐
History of heart problems in immediate family	☐	Diabetics unless medical permission is sought	☐	Smokers	☐

Written permission required by – *Either of which should be attached to the treatment form (Select if/where appropriate):*			
GP/specialist	☐	Informed client	☐

Personal information – *(Select if/where appropriate):*				
Muscular/skeletal problems:	Back ☐	Aches/pain ☐	Stiff joints ☐	Headaches ☐
Digestive problems:	Constipation ☐	Bloating ☐	Liver/gall bladder ☐	Stomach ☐
Circulation:	Heart ☐	Blood pressure ☐	Fluid retention ☐	Tired legs ☐
	Varicose veins ☐	Cellulite ☐	Kidney problems ☐	Cold hands and feet ☐
Gynaecological:	Irregular periods ☐	P.M.T ☐	Menopause ☐	H.R.T ☐
	Pill ☐	Coil ☐	Other:	
Nervous system:	Migraine ☐	Tension ☐	Stress ☐	Depression ☐
Immune system:	Prone to infections ☐	Sore throats ☐	Colds ☐	Chest ☐
	Sinuses ☐			
Regular antibiotic/medication taken?				
If yes, which ones:			Yes ☐	No ☐
Herbal remedies taken?				
If yes, which ones:			Yes ☐	No ☐
Ability to relax:	Good ☐	Moderate ☐	Poor ☐	
Sleep patterns:	Good ☐	Poor ☐	Average no. of hours:	
Do you see natural daylight in your workplace?	Yes ☐	No ☐		
Do you work at a computer?	Yes ☐	No ☐	If yes, how many hours:	
Do you suffer/have suffered from?	Dermatitis ☐	Eczema ☐	Psoriasis ☐	Allergies ☐
	Acne ☐	Hay fever ☐	Asthma ☐	Skin cancer ☐
In terms of your normal, everyday lifestyle, what would you say your general stress level is (1-10, 10 being the highest)	At work:		At home:	
And what would you say your stress level is at present?	1-2 ☐	3-4 ☐	5-6 ☐	7-8 ☐
	9-10 ☐			

Do you eat regular meals?	Yes ☐	No ☐		
Do you eat in a hurry?	Yes ☐	No ☐		
Do you take food/vitamin supplements?	Yes ☐	No ☐	If yes, which ones:	
How many portions of each of these items does your diet contain per day?	Fresh fruit	Fresh vegetables	Protein and source:	
	Dairy produce	Sweet things	Added salt	Added sugar
How many units of these drinks do you consume per day?	Tea:	Coffee:	Fruit juice:	Water:
	Soft drinks:	Other:		
Do you suffer from food allergies?	Yes ☐	No ☐		
Bingeing?	Yes ☐	No ☐		
Overeating?	Yes ☐	No ☐		
Do you smoke?	Yes ☐	No ☐	How many per day:	
Do you drink alcohol?	Yes ☐	No ☐	How many units per day:	

Full diet plan taking into account the clients current lifestyle with a rationale for the plan:

Feedback to show evidence of the progression of weight management over a four week period to include nutritional advice given:

Overall conclusion, including recommendations given for future weight management and reflective practice:

Date of diet: _____ **Start**: _____ **End date**: _____

Client signature: _____

Learner signature: _____

Date: _____

iUSP154 – Personal Exercise History Questionnaire

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Do you carry out any form of exercise at the moment?	Yes ☐		No ☐	
If No:				
How often would you be able to exercise? (times per week)	1-2 times ☐	3-4 times ☐	5-6 times ☐	7+ ☐
When is the most convenient time for you to exercise?	Morning ☐	Afternoon ☐	Evening ☐	
What type of exercise would you prefer to do?				
What do you want to get out of your exercise programme? (goals and expectations)				

If yes:				
What sort of exercise do you do?	Gym ☐	Exercise classes ☐	Walking ☐	Yoga/pilates ☐
	Running ☐	Team sports ☐	Swimming ☐	Weights/ resistance ☐
	Endurance ☐	Other ☐		
How long have you been exercising for?	1 month ☐	2 months ☐	3-6 months ☐	Longer ☐
Do you enjoy exercising?	Yes ☐		No ☐	
What are your likes/dislikes about exercising?	Likes:		Dislikes:	
How often do you exercise at the moment?	1-2 times ☐	3-4 times ☐	5-6 times ☐	7+ ☐

Learner signature: _____

Client signature: _____

iUSP154 – Personal Training Follow Up Sheet

Fitness test:				
Heart rate:	Resting:	Training:	Maximum:	
Blood pressure:				
Anthropometrics:	Height:	Weight:	BMI:	
	Waist circumference or wait to hip ratio:			
Body composition:				
Cardiorespiratory test (state which one and for how long):				
Flexibility test:	Trunk flexion:	Trunk extension:	Hip flexion:	Shoulder flexion:
Muscle strength test:	Isometric:	Isokinetic:	Isotonic/dynamic:	
Muscle endurance – how many?	Push-ups:	Bent knee curl:	Bench press:	Abdominal curl/sit-up test:

Detailed exercise recommendations including rationales, alternatives, variety, progressions expected and achieved:

Details of how the client felt during and after each session:

Details of home care advice given after each session:

Overall conclusion, including recommendations given for future exercising and reflective practice:

Client signature: _____

Instructor/student signature: _____

Date: _____

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Fitness test:				
Heart rate:	Resting:	Training:	Maximum:	
Blood pressure:				
Anthropometrics:	Height:	Weight:	BMI:	
	Waist circumference or waist to hip ratio:			
Body composition (e.g. callipers, bio-electrical impedance etc.):				
Cardiorespiratory test (state which one and for how long):				
Flexibility test:	Trunk flexion:	Trunk extension:	Hip flexion:	Shoulder flexion:
Muscle strength test:	Isometric:	Isokinetic:	Isotonic/dynamic:	
Muscle endurance – how many?	Push-ups:	Bent knee curl:	Bench press:	Abdominal curl/sit-up test:

Detailed exercise recommendations including rationales, alternatives, variety, progressions expected and achieved:

Details of how the client felt during and after each session:

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Overall conclusion, including recommendations given for future exercising and reflective practice:

Client signature: _____

Instructor/student signature: _____

Date: _____

Document History

Version	Issue Date	Changes	Role
v1	27/09/2019	First published	Qualifications Administrator