

Client intake form

Filled in by the client before the first diet and the first program.

Name: _____ Date of birth: _____

Height (cm): _____ Weight (kg): _____ Job: _____

Goal

☐ Fat loss ☐ Muscle gain ☐ Recomposition ☐ Strength ☐ Maintenance

Why now, and what stopped you until today?

Training history and equipment

Sports practised: _____ Sessions per week today: _____

Gym or home: _____ Equipment available: _____

Strength training level

☐ Beginner ☐ Intermediate ☐ Advanced

Daily activity, outside training

☐ Sedentary ☐ Lightly active ☐ Active ☐ Very active

Possible days and times

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning							
Midday							
Evening							

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Health

Answer honestly. If you answer yes to any question, ask your doctor before you start.

Has a doctor ever told you that you have a heart condition? ☐ Yes ☐ No

Do you feel pain in your chest, during effort or at rest? ☐ Yes ☐ No

Have you ever fainted or felt dizzy during effort? ☐ Yes ☐ No

Do you have a bone or joint problem that effort could make worse? ☐ Yes ☐ No

Do you take medication for blood pressure or for your heart? ☐ Yes ☐ No

Are you pregnant, or did you give birth less than six months ago? ☐ Yes ☐ No

Do you know any other reason not to exercise without medical advice? ☐ Yes ☐ No

Injuries, pain or surgery to know about:

Eating habits

☐ Standard ☐ Vegetarian ☐ Vegan ☐ Lactose free ☐ Gluten free

Meals per day: _____ Hours of sleep: _____

Allergies or intolerances: _____

Foods you refuse: _____

Alcohol per week: _____

Date: _____ Signature: _____

This form does not replace medical advice. The answers stay between the client and their coach.