DISCOVERY FORM

MEDICAL HISTORY

The information contained within will be treated as confidential and will not released or revealed without your written consent.

FULL NAME _____

ADDRESS _____

EMAIL: _____ **MOBILE:** _____

D/O/B: _____ **OCCUPATION:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

DOCTORS NAME: _____ **PHONE:** _____

DO YOU HAVE OR HAVE YOU EVER HAD (PLEASE TICK) :

1.	HIGH BLOOD PRESSURE?	Yes	No		
2.	HIGH CHOLESTEROL / TRIGLYCERIDES?	Yes	No		
3.	PAIN / TIGHTNESS IN THE CHEST?	Yes	No		
4.	FAINT OR DIZZY SPELLS?	Yes	No		
5.	STOMACH / DUODENAL ULCER?	Yes	No		
6.	LIVER / KIDNEY CONDITION?	Yes	No		
7	RHEUMATIC FEVER?	Yes	No		
8.	ANY HEART CONDITIONS / STROKE?	Yes	No		
9.	GOUT?	Yes	No		
10.	DIABETES?	Yes	No		
11.	EPILEPSY?	Yes	No		
12.	ARE YOU PREGNANT?	Yes	No		
13.	CARTILAGE OR LIGAMENT PROBLEMS?	Yes	No		
14.	MUSCULAR OR JOINT PROBLEMS?	Yes	No		
15.	ARE YOU A MALE OVER 35 YEARS OR FEMALE OVER 45 YEARS?	Yes	No		

DO YOU HAVE OR HAVE YOU EXPERIENCED

1.	A FAMILY HISTORY OF HEART DISEASE, STROKE OR RAISED CHOLESTEROL OF RELATIVES UNDER THE AGE OF 65?	Yes	No		
2.	BREATHING DIFFICULTIES OR ASTHMA?	Yes	No		
3.	A HERNIA?	Yes	No		
4.	ARTHRITIS?	Yes	No		
5.	BACK PAIN?	Yes	No		
6.	MUSCULAR PAIN / CRAMPS?	Yes	No		
7.	ANY MAJOR INJURIES?	Yes	No		
8.	DO YOU SMOKE?	Yes	No		
9.	ARE YOU ON ANY PRESCRIBED MEDICATION?	Yes	No		
10.	HAVE YOU BEEN HOSPITALISED RECENTLY?	Yes	No		
11.	DO YOU HAVE / RECENTLY HAD ANY INFECTIONS OR INFECTIOUS DISEASES?	Yes	No		
12.	ARE THERE ANY OTHER CONDITIONS OR PATHOLOGIES, WHICH MAY LIMIT PERFORMANCE IN OR ABILITY TO PERFORM AN EXERCISE PROGRAM?	Yes	No		

MEDICAL HISTORY

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PLEASE LIST FURTHER DETAILS OF ANY QUESTIONS YOU ANSWERED 'YES' TO:

LIFESTYLE

ELYSIAN

HOW MANY HOURS DO YOU WORK A WEEK?:

10+ 20+ 30+ 40+ 50+ 60+

HOW WOULD YOU DESCRIBE THE LEVEL OF ACTIVITY OF YOUR WORK?

Sedentary Moderately Active Fairly Active Very Active

HOW OFTEN DO YOU TRAVEL FOR WORK?

Rarely A few times a year A few times a month Weekly

HOW MANY ALCOHOLIC DRINKS WOULD YOU HAVE A WEEK ON AVERAGE?

1-2 3-4 5-6 7-8 9-10 More

PLEASE INDICATE BELOW HOW IS THAT TYPICALLY SPREAD OUT OVER THE WEEK.

Monday_____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday_____

ARE YOU EXPERIENCING ANY TYPE OF STRESS IN YOUR LIFE AT THE MOMENT?

HOW MANY HOURS ON AVERAGE WOULD YOU SLEEP EVERY NIGHT?

5 hours 6 hours 7 hours 8 hours

DESCRIBE YOUR SLEEP PREPARATION PROCESS BEFORE BED...

LIFESTYLE

ELYSIAN

ARE YOU CURRENTLY SEEING ANY OTHER ALLIED HEALTH CARE PROFESSIONAL?

HEALTH PROFESSIONAL	FULL NAME	PHONE	EMAIL
Physiotherapist			
Occupational Therapist			
Massage Therapist			
Naturopath			
General Practitioner			
Nutritionist / Dietitian			
Exercise Physiologist			
Osteopath			
Chiropractor			
Sports Doctor			
Specialist			
Other			

NUTRITION

ELYSIAN

PLEASE INDICATE WHAT IS A TYPICAL WEEK DAY NUTRITION FOR YOU AT THE MOMENT

MEAL & TIME	DESCRIPTION
BREAKFAST	
MID MORNING	
LUNCH	
MID AFTERNOON	
DINNER	
EXTRA SNACKS	

PLEASE INDICATE WHAT IS A TYPICAL WEEKEND NUTRITION FOR YOU AT THE MOMENT

MEAL & TIME	DESCRIPTION
BREAKFAST	
MID MORNING	
LUNCH	
MID AFTERNOON	
DINNER	
EXTRA SNACKS	

NUTRITION

ELYSIAN

PLEASE INDICATE BELOW, HOW MANY GLASSES OF WATER WOULD YOU DRINK A DAY.

10+ 3-4 5-6 7-8 9-10

PLEASE LIST ALL NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING.

GOALS

ELYSIAN

PLEASE TICK THE MAIN BENEFITS YOU WANT FROM YOUR EXERCISE AND DIET PROGRAM

FAT LOSS	IMPROVED FITNESS	MUSCLE DEFINITION
INCREASE MUSCLE	GOOD HEALTH	MAINTAIN FITNESS
FLEXIBILITY	SPORTS TRAINING	BODYBUILDING COMPETITION
WEIGHT LOSS	STRENGTH	OTHER _____

WANTS TO ACHIEVE:

TRAINING HISTORY:

CURRENTLY DOING:

GOALS

ELYSIAN

GOALS IN ORDER OF PRIORITY:

1.

2.

3.

4.

5.

HOW MANY TIMES PER WEEK ARE YOU WILLING TO COMMIT TO TRAINING TO ACHIEVE YOUR GOALS?

1 2 3 4 5 6 7

HOW MANY TIMES HAVE YOU TRIED AND FAILED AT A FITNESS GOAL BEFORE?:

1 2 3 4 5

PLEASE TICK THE AREAS OF TRAINING YOU FEEL YOU NEED MOST HELP WITH.

PROGRAM CARDIO MOTIVATION WEIGHTS DIET/EATING PLAN OTHER

IN 3 MONTHS TIME, WHAT WOULD YOU LIKE TO HAVE ACHIEVED? WHY?

IN 6 MONTHS TIME, WHAT WOULD YOU LIKE TO HAVE ACHIEVED? WHY?

IN 12 MONTHS TIME, WHAT WOULD YOU LIKE TO HAVE ACHIEVED? WHY?

SELF APPRAISAL

ELYSIAN

HOW IMPORTANT IS IT FOR YOU TO ACHIEVE YOUR GOALS ON A SCALE OF 1-10? WHY?

1 2 3 4 5 6 7 8 9 10

ON A SCALE OF 1-10, HOW COMMITTED TO CHANGE ARE YOU? WHY?

1 2 3 4 5 6 7 8 9 10

PLEASE TICK THE MOST APPROPRIATE SENTENCE THAT DESCRIBES HOW READY YOU ARE NOW TO ACHIEVE BETTER HEALTH & FITNESS

IT WOULD BE NICE	I'D LIKE TO DO IT
I WILL DO IT	NOTHING CAN STOP ME FROM ACHIEVING MY GOALS!!

WHAT WOULD IT FEEL OR LOOK LIKE FOR YOU TO NOT ACHIEVE YOUR GOALS? WHY?

HOW LONG HAVE YOU BEEN THINKING ABOUT ACHIEVING THESE GOALS?

WHEN WOULD YOU LIKE TO GET STARTED

Now 2 weeks 4 weeks 3 months Other

DO YOU HAVE A PARTNER, AND IS YOUR PARTNER SUPPORTIVE OF YOU ACHIEVING YOUR GOALS?

DOES YOUR PARTNER NEED TO BE INVOLVED IN THE DECISION MAKING PROCESS?

ARE YOU PREPARED TO DO WHAT IT TAKES TO ACHIEVE YOUR GOALS? IF YES, IDENTIFY WHAT COULD STOP YOU?

SELF APPRAISAL

ELYSIAN

WOULD YOU AGREE THAT COMMITTING TO YOUR HEALTH & FITNESS GOALS IS THE FIRST STEP TO ACHIEVING YOUR DESIRED RESULTS? WHY?

WHAT'S IT COSTING YOU RIGHT NOW NOT HAVING THIS EXPERT SUPPORT IN PLACE?

WHAT ARE THE TOP 3 BENEFITS THAT YOU WOULD VALUE MOST FROM HAVING EXPERT AND SPECIALISED COACHING, THAT YOU HAVEN'T HAD IN THE PAST?

1.

2.

3.

PLEASE INDICATE BELOW, WHAT ARE YOU PREPARED TO INVEST ON A WEEKLY BASIS TO ACHIEVE THESE GOALS

$100+ $200+ $300+ $400+ $500+

WHAT COULD YOU GIVE UP IN YOUR LIFE RIGHT NOW TO MAKE THIS FINANCIALLY POSSIBLE?

WHO DO YOU KNOW THAT COULD BENEFIT FROM EXPERT HEALTH & FITNESS COACHING LIKE YOU'RE ABOUT TO GET?
Please write their name, mobile and email and we'll give them a call. For every person that signs from your referral, you will get a FREE session

Referral 1

Referral 2

Referral 3

ADDITIONAL COMMENTS:

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