



# Lifestyle Questionnaire

**Assessing your needs:** all the information received on this form will be kept strictly confidential. Please fill out the forms *completely and accurately.*

Name:  DOB  Age:

Address:

Phone: (home)  (work)  (mobile)

Email Address:  Occupation:

GP's name:  Phone

Karen Murphy

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**Cardiovascular risk factors** (place an **X** in the appropriate box if the answer is 'yes')

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

- you are a man older than 55 years
- you are a woman older than 65 years
- you had a hysterectomy, or you are postmenopausal
- you smoke, or quit within the previous 6 months
- you don't know your BP
- your BP is greater than 140/90mmHg
- you take BP medication
- your blood cholesterol level is >5.2mmol/L
- you don't know your cholesterol level

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

- you have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
- you are physically inactive (i.e. you take less than 30 minutes of physical activity less than 3 days per week)
- you more than 9Kg over weight

*If you marked any of the statements in this section, consult your GP or other appropriate healthcare provider before engaging in exercise. You may need to use a facility with **medically qualified staff**.*

Karen Murphy

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*Other health issues (place an X in the appropriate box if the answer is 'yes')*

<input type="checkbox"/>	you have diabetes
<input type="checkbox"/>	you have asthma or other lung disease
<input type="checkbox"/>	you have burning or cramping sensation in your lower legs when walking a short distance
<input type="checkbox"/>	you have a musculoskeletal problem that limits your physical activity
<input type="checkbox"/>	you have concerns about your safety during exercise
<input type="checkbox"/>	you take prescription medication(s) What are they?
<input type="checkbox"/>	you are pregnant or have been in the last 6 months?

*If you marked 2 or more of the statements in this section, you should consult your GP or other appropriate healthcare provider before engaging in exercise.*

**Physical activity** (place an X in the appropriate box)

1. In the last year how often have you participated in physical activity?

<input type="checkbox"/>	3-4 times per week
<input type="checkbox"/>	1-2 times per week
<input type="checkbox"/>	1-2 times per month
<input type="checkbox"/>	Not at all

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4. What types of physical activity do you enjoy?

5. What don't you enjoy and why not?

6. Do you have any negative feelings toward, or have you had any bad experience with exercise? (If yes please give details)

**Client**

**Signature.....Date.....**

**Trainers Signature.....Date.....**

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