djohns
PERSONAL TRAINING & FITNESS

Darien Johns 0403 543 652
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CLIENT NUTRITION
CONSULTATION FORM

PERSONAL DETAILS

First Name: .....

Surname: .....

D.O.B: .....

Gender: .....

Contact Number: .....

Email: .....

MEDICAL HISTORY

Are you currently taking any medication?: .....

If yes, please provide details: .....

.....

.....

How would you rate your overall health on a scale of 1 to 10?: .....

1 = Very Bad / 10 = Very Good

HEALTH & FITNESS GOALS

Which of the following is most important to you right now?

- ☐ I want to gain weight/muscle
- ☐ I want to lose weight/fat
- ☐ I want to maintain weight

Height: .....

Current Bodyweight (kgs): .....

Current Bodyfat (%): .....

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NUTRITION

Do you have any food allergies, intolerances or sensitives?.....

If yes, please provide details: .....

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.....

.....

What are your favourite foods? .....

.....

.....

.....

What foods do you dislike?.....

.....

.....

.....

How many meals per day fits your lifestyle best?.....

Do you use any training/performance enhancing stimulants or supplements? .....

If yes, please provide details: .....

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What time of day do you train? (e.g. before breakfast, before dinner) .....

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