METINA

TAILORED PERSONAL TRAINING

DATE

BEFORE WE START

Health questionnaire

Your answers let me adapt every session to your body and health, safely. Please answer honestly. About 8 minutes.

01 Identity

FULL NAME

SEX

PHONE

EMAIL

OCCUPATION

Work:

☐ Mostly sitting ☐ Standing / moving ☐ Physical

02 Measurements

AGE

HEIGHT (CM)

WEIGHT (KG)

RESTING HEART RATE (BPM)

03 Physical activity

Do you currently do any sport? ○ Yes ○ No

Which one, how often per week?

Have you stopped exercising for a long time? ○ Yes ○ No

Since when?

Current level:

☐ I don't exercise ☐ Beginner ☐ Intermediate ☐ Advanced

04 Stress and energy

Daily stress:

LOW ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 VERY HIGH

Daytime energy:

VERY LOW ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 VERY HIGH

Main source of stress right now:

05 Health

> If you answer yes to any of questions 1 to 7, ask your doctor before starting.

1. Heart problem or high blood pressure? ◯ Yes ◯ No

Which one, since when, medical follow-up? _____

2. Chest pain, at rest or during exercise? ◯ Yes ◯ No

When and how? _____

3. Dizziness or fainting in the last 12 months? ◯ Yes ◯ No

How often, in what situation? _____

4. Chronic illness (diabetes, asthma, epilepsy…)? ◯ Yes ◯ No

Which one? _____

5. Current treatment (medication, physio, other)? ◯ Yes ◯ No

Which one, what for? _____

6. Medical advice to avoid certain efforts? ◯ Yes ◯ No

Which ones? _____

7. Pregnant, or gave birth in the last 6 months? ◯ Yes ◯ No

Week of pregnancy or birth date _____

8. Joint, back or other problems? ◯ Yes ◯ No

Where, what kind? _____

9. Breathing problems? ◯ Yes ◯ No

Which ones? _____

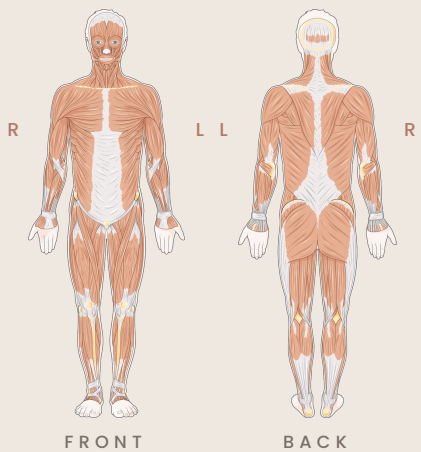
10. Surgery or major injuries? ◯ Yes ◯ No

Which ones, and when? _____

11. Smoking? ◯ Yes ◯ No

What, how much per day? _____

06 Pain



Illustrations: Servier Medical Art, smart.servier.com, CC BY 4.0

Circle or shade the areas where you have pain or discomfort, even mild.

Intensity of the worst pain:

☐ Mild ☐ Moderate ☐ Strong

Since when, and when does it occur (at rest, during exercise, in the morning…)?

_____

_____

07 Sleep

Hours of sleep per night:

☐ Under 6 h ☐ 6–7 h ☐ 7–8 h ☐ Over 8 h

Sleep quality:

POOR ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 EXCELLENT

Do you often wake up at night? ○ Yes ○ No

Do you feel rested when you wake up? ○ Yes ○ No

Do you use a screen in the hour before bed? ○ Yes ○ No

08 Nutrition

Do you think you eat well?

NOT AT ALL ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 VERY WELL

Meals per day:

☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Water per day:

☐ Under 1 L ☐ 1–1.5 L ☐ 1.5–2 L ☐ Over 2 L

Alcohol:

☐ Never ☐ Occasionally ☐ Every week ☐ Almost every day

Food allergies or intolerances? ○ Yes ○ No

Which ones? _____

Special diet (vegetarian, vegan, halal, gluten-free…): _____

09 Declaration

I confirm my answers are accurate and I will tell my coach if my health changes. If I answered "yes" to questions 1 to 7, or if in doubt, I will see a doctor before starting. I train at my own risk and follow my coach's instructions. To the extent permitted by law, METINA accepts no liability for damage caused by inaccurate information or by not following instructions (gross negligence excepted, art. 100 Swiss CO). I agree that my health data is used only to adapt my programme.

> **Coach's commitment.** I will keep this information strictly to myself, never share it without your consent, and use it only to build a programme adapted to your health.

PLACE AND DATE _____

SIGNATURE _____