Andy Brodziak
CORRECTIVE EXERCISE TRAINER
& PERFORMANCE COACH

ANDY BRODZIAK - CORRECTIVE EXERCISE TRAINER

www.andybrodziak.com - 0793 171 8410

All of the information you provide in this questionnaire is strictly confidential and will become part of your training record.

Client Name (please print):____________________________

If you tick "yes" to any of these questions, please provide details such as date of occurrence, frequency, intensity, etc.

1. **Do you suffer from back pain? * No *Yes**
2. **Are you sensitive to touch/pressure in any* No *Yes area?**
3. **Do you have tension, numbness or pain in a* No *Yes specific area?**
4. **Do you experience frequent* No *Yes headaches?**
5. **Are you pregnant? * No *Yes If yes, when are you due:**
6. **Do you have high blood pressure?* No *Yes**
7. **Do you have high cholesterol?* No *Yes**
8. **Are you epileptic?* No *Yes**
9. **Have you ever had surgery?* No *Yes**
10. **Have you ever broken any bones? * No *Yes**
11. **Do you experience stiff, swollen or painful* No *Yes joints?**
12. **Do you have difficulty* No *Yes sleeping?**
13. *** No *Yes Do you experience fatigue or lack of energy?**
14. *** No *Yes Do you experience cold hands or feet?**
15. *** No *Yes Have you ever been advised by a physician to avoid any type of exercise?**
16. **Have you ever been knocked unconscious or suffered* No *Yes a concussion?**
17. **Do you (or does someone in your family) have a cardiac* No *Yes condition?**
18. **Do you have any allergies?* No *Yes**
19. **Are you currently taking* No *Yes any medications?**
20. **Have you ever seen a Nutritionist/Registered* No *Yes Dietician?**
21. *** No *Yes Do you smoke or have you smoked in the past?**
22. *** No *Yes Do you live with a smoker?**
23. *** No *Yes Do you drink coffee?**
24. **What is your "chief complaint" (if applicable):**
25. **Please state how long you have had this complaint, when you first noticed it and what you feel may have caused the problem:**
26. **How does your "chief complaint" affect you on a day-to-day basis? Please state what you CAN and CANNOT do any more.**
27. **Are the symptoms brought on by certain activities or* No *Yes positions?**
28. *** No *Yes Is the pain worse at certain times of day?**
29. **Do specific activities or positions alleviate your* No *Yes symptoms?**
30. **Do you have an ergonomically set up* No *Yes desk/workstation?**
31. **How many hours do you spend in front of a computer?**
32. **On a scale of 1 to 10 (1=no stress, 10=a lot of stress), please rate the amount of stress in your career.**
33. **On a scale of 1 to 10 (1=no stress, 10=a lot of stress), please rate the amount of stress in your personal life.**
34. **What is the heaviest you have weighed, and how old were you at that time?**
35. **What previous treatment(s) have you tried? Please state what and when.**
36. **Have you ever had any of the following: physical therapy, chiropractic, massage, acupuncture, Feldenkrais, rolfing, Alexander technique, Other? Please elaborate.**
37. **What time do you usually go to bed at night and wake up in the morning?**

38. **How many meals do you eat each day? List the number and time of day you usually eat these meals.**
39. **How many days do you have to commit towards working out?**
40. **Are there any areas of your body you want to specifically work on?**

Client Signature : ______________________________ Date : ___________