SECTION 1: DEMOGRAPHICS	
Name:	Surname:
Date of Birth:	Gender:
Mobile Number:	Email Address:
Membership Number:	Suffix:
Type of work: Sedentary(non-manual) ☐ Manual ☐	Please specify Occupation

SECTION 2: MEDICAL HISTORY			
State whether or not you have suffered from the following:			
High Blood pressure	☐ Yes ☐ No	Heart disease/weak heart/strained	☐ Yes ☐ No
Obesity/Overweight	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No	Stress/Anxiety/Depression	☐ Yes ☐ No
Do you suffer from back pain? ☐ Yes ☐ No	If yes how often? ☐ Not often ☐ Often ☐ Very Often		
What is your average sleeping duration: ☐ less than 5 hours ☐ 5-8 hours ☐ more than 8 hours			

SECTION 3: FAMILY AND SOCIAL HISTORY		
Do you smoke? ☐ Yes ☐ No	If yes, how many years? ☐	If yes, average cigarettes per day? ☐
Do you drink alcohol? ☐ Yes ☐ No	If yes, chose how much you drink ☐ 2 or less pints per day ☐ More than 2 pints per day	
Do you do any physical exercises? ☐ Yes ☐ No If yes, how frequent? ☐ 1-2 times a week ☐ 3-5 times a week ☐ More than 5 times a week		
Do you consider yourself as someone who eats a healthy balanced diet? ☐ I never do this ☐ Sometimes do this ☐ Always do this		

SECTION 4: HEALTH TESTS			
Systolic Blood Pressure		Height/m	
Diastolic Blood Pressure		Weight/kg	
Pulse/BPM		BMI(Weight kg/Height m^2)	
Blood Glucose/mmols		Waist circumference/cm	
		Hip circumference/cm	

How would you rate your readiness to change should you be advised or initiated in any program meant to improve your health related behaviour? Choose appropriate box below:

Not ready ☐ Not sure ☐ Ready ☐ Very ready ☐

CLICK TO SUBMIT FORM