Healthy Steps Exercise and Wellbeing Programme Consultation Form

Consent Form

Terms and Conditions

Parties: 'I' 'my' refer to Andrea Meszaros as your coach, 'you' 'your' refer to a participant in Healthy Steps Programme.

Healthy Steps Forms consist Consent Form, Physical Activity Readiness Questionnaire (Par-Q), Consultation Form, Measurement Sheet, Food and Drink Diary, Activity Diary.

Filling out these forms contribute to my work to create a plan for you to give support in reaching your goals according giving informations and preferences.

Your details will not be passed to third party without your written consent and will be kept confidential.

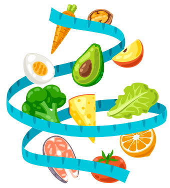
Your given informations can be used in my reference studies anonymously which means no name and personal contactcs are being shard.

Taking part in Healthy Steps Programme means you are willing to undertake aggreed actions to reach your goals and taking responsibility for your dos and don'ts.
If any action needs further professional help you will be refer to a professional. I will not taking any responsibility if you are continue actions over that point.

☐ I have read and understood all terms and conditions.

Name: Date:

Healthy Steps Exercise and Wellbeing Programme Consultation Form

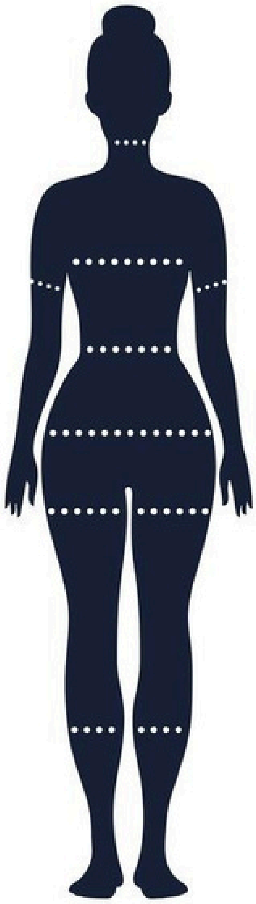


Measurement Form

Age: **Height:**

Body Measurements

Before	After
DATE ________	DATE ________
NECK ________	NECK ________
CHEST ________	CHEST ________
LEFT ARM ________	LEFT ARM ________
RIGHT ARM ________	RIGHT ARM ________
WAIST ________	WAIST ________
HIPS ________	HIPS ________
LEFT THIGH ________	LEFT THIGH ________
RIGHT THIGH ________	RIGHT THIGH ________
LEFT CALF ________	LEFT CALF ________
RIGHT CALF ________	RIGHT CALF ________
WEIGHT ________	WEIGHT ________



Body Measurements

Before	After
DATE ________	DATE ________
NECK ________	NECK ________
CHEST ________	CHEST ________
LEFT ARM ________	LEFT ARM ________
RIGHT ARM ________	RIGHT ARM ________
WAIST ________	WAIST ________
HIPS ________	HIPS ________
LEFT THIGH ________	LEFT THIGH ________
RIGHT THIGH ________	RIGHT THIGH ________
LEFT CALF ________	LEFT CALF ________
RIGHT CALF ________	RIGHT CALF ________
WEIGHT ________	WEIGHT ________

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Body Measurements

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DATE ________	DATE ________
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RIGHT ARM ________	RIGHT ARM ________
WAIST ________	WAIST ________
HIPS ________	HIPS ________
LEFT THIGH ________	LEFT THIGH ________
RIGHT THIGH ________	RIGHT THIGH ________
LEFT CALF ________	LEFT CALF ________
RIGHT CALF ________	RIGHT CALF ________
WEIGHT ________	WEIGHT ________

Physical Activity Readiness Questionnaire (PAR-Q)

This questionnaire is designed to help me learn what I need to know to help you stay safe and healthy during exercise while reaching your goals. Please take your time and fill out this questionnaire as honestly as possible.

About You

Name:	**Email:**
Address:	**Date of birth:**
Phone Number:	**Gender pronouns:**
What's the best way to contact you? ☐ Call ☐ Text ☐ Email ☐ Other: _____	
Emergency Contact Name:	**Relationship:**
Emergency Contact Phone Number:	

Consent:

I am aware that aromatherapy in a form of essential oils in aroma diffuser is used in class.

☐ Yes

Your Health

Primary Care Provider (PCP) Name:
PCP Phone Number/Email Address:
Permission to Contact PCP if Needed: ☐ Yes ☐ No

	Yes	No
1. Has your doctor ever said that you have a heart condition and that you should only perform medically supervised physical activity?	☐	☐
2. Do you feel pain in your chest when you perform physical activity?	☐	☐
3. In the past month, have you had chest pain when you were not performing any physical activity?	☐	☐
4. Do you lose your balance because of dizziness, or do you ever lose consciousness?	☐	☐
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?	☐	☐
6. Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?	☐	☐
7. Do you know of any other reason why you should not engage in physical activity?	☐	☐
8. Have you been diagnosed with liver disfunction?	☐	☐
9. Have you been suffering from epilepsy?	☐	☐
10. Are you pregnant or nursing?	☐	☐

Please check the box that applies to you below:

☐ 1. I answered NO to all questions above, and I have been cleared by my healthcare provider for exercise.

☐ 2. I answered NO to all questions above, and I have NOT been cleared by my healthcare provider for exercise.

☐ 3. I answered YES to one or more questions above, my healthcare provider is aware of these health conditions, and they have cleared me for exercise.

☐ 4. I answered YES to one or more questions above, and I have NOT been cleared by my healthcare provider for exercise.

If you checked box 1 or 3, please sign the release below.

If you checked box 2 or 4, I highly recommend getting clearance from your healthcare provider before starting an exercise program. Please ask them to provide a signed clearance form and give it to me, along with this PAR-Q form.

Disclaimer and Release

☒ I, the undersigned, have read, understood to my full satisfaction, and completed this questionnaire.

☒ I understand that if my health changes, I must inform my coach and check with my PCP that I'm still cleared for exercise.

☒ I recognize that it is my responsibility to work directly with my PCP before, during, and after seeking fitness and/or nutrition consultation.

☒ I understand that any information provided is not to be followed without prior approval of my PCP. If I choose to use this information without such approval, I agree to accept full responsibility for my decision.

☒ I acknowledge that my coach may retain a copy of this form for their records. In these instances, they will maintain the confidentiality of the same, complying with applicable law.

Signature:	**Date:**

Setting Boundaries

Throughout our coaching partnership, there may be things that come up that you are or are not comfortable talking about. Topics such as your menstrual cycle (or lack thereof), pelvic floor health, nutrition, sleep, and stress may all have an impact on your training and your results to varying degrees.

Please indicate which topics you are comfortable talking about with me by checking the relevant boxes (or checking the first box if you are comfortable talking about all of them). If you are not comfortable talking about a certain issue with me, leave the box(es) blank. You may change your decision at any time.

As you go through the rest of this form, feel free to leave any questions you don't feel comfortable answering blank.

I am comfortable talking about all of the topics listed below.

☐ I am only comfortable talking about these specific topics:

Menstrual cycle
Pelvic floor health
Incontinence
Pelvic organ prolapse
Menopause
Nutrition
Eating habits and behaviors
Sleep
Stress
Emotional issues and mental health
Body image
Weight
Other: _____

There may also be instances where it can be helpful for me to manually cue or manually assess you, which requires physical touch.

Please indicate which body parts you are comfortable having me manually cue or assess by checking the relevant boxes (or checking the first box if you are comfortable having me manually cue or assess all of them). If you are not comfortable having certain areas (or any part of your body) touched for cueing or assessment, leave the box(es) blank. You may change your decision at any time.

In addition to your consent here, I will also obtain your verbal consent before manually cueing or assessing you during a training session.

I am comfortable with my coach manually cueing and manually assessing all the body parts listed on the next page.

☐

I am only comfortable with my coach manually cueing and manually assessing these specific body parts:

Feet Abdomen
Legs Upper back
Hands Lower back
Arms Neck
Head Other: _____
Glutes

Medical History

Do you have a previous history of injury, pain, or physical limitations with any body parts? If so, please explain:

Have you ever had surgery? If so, when and for what:

Are you currently experiencing or have you recently experienced any muscle or joint pain?

Yes ☐ No ☐ Unknown ☐

If you answered yes, please explain:

Do you currently or have you ever experienced any of the following? If so, please check the boxes and provide relevant details in the space provided below.

MUSCULOSKELETAL

- Central pubic area pain
- Coccyx (tailbone) damage or pain
- Lower back pain
- Pins and needles – location: _____
- Shooting or radiating pain in back, glutes, or legs – location: _____
- Abdominal bulging or doming
- Neck pain
- Knee pain
- Other joint pain (please specify): _____
- Other (please specify): _____

PELVIC HEALTH

- Heaviness, dragging, or bulging in the pelvic area
- Pain in the pelvic area
- Diagnosis of pelvic organ prolapse
- Leaking urine while coughing, sneezing, exercising, or exerting yourself
- Strong and sudden urge to urinate
- Leaking of urine at rest
- Difficulty or discomfort w/ passing urine
- Uncontrollable gas
- Leaking of feces
- Straining during bowel movements
- Pain in the perineum during sexual intercourse (or any other time)
- Unexplained bleeding during or after exercise

OTHER

- Hemorrhoids
- Varicose veins
- Constipation
- Gestational diabetes
- Low blood pressure
- Preeclampsia
- High blood pressure
- Other (please specify): _____

Use this space to provide details on any boxes checked above. Please include when symptoms started/diagnosis happened, any treatment(s), and current status.

Have you met with any of the following healthcare professionals in the past 12 months?

Physiotherapists Chiropractors
Acupuncturists Other (please specify): _____

Please describe the reason(s) for your visit(s):

Your Past Birth Experience(s)

Please fill out this section if you've experienced birth in the past. If you haven't, skip down to "Your Health Details."

Date(s) of birth:

Birth type: Vaginal Assisted C-section

Tearing: Yes No If yes, degree of tearing (if known):

Are you currently breastfeeding? Yes No

Is there anything else you want me to know about your past birth experience(s)?

Your Health Details

Have you been diagnosed (currently or in the past) with any significant medical conditions and/or injuries that you haven't mentioned yet? Please check all that apply.

Heart condition
Blood disorder
Asthma
Osteoporosis
Cancer
Knee pain or injury
Type 1 diabetes
Neck pain or injury
Type 2 diabetes
Back pain or injury
Autoimmune condition
Other (please list)
Thyroid disease
Seizures
Fibromyalgia
Arthritis

Use the space below to provide details on any boxes checked above.

Are you taking any medications, either over-the-counter or prescription? If so, list them all below.

Have you ever had surgery or experienced any other major medical event you want me to know about? If so, use the space below to share what happened, and when.

ENVIRONMENT

Who do you live with? (e.g., spouse/partner, parents, roommates, pets, children)

What, if any, major obstacles are you encountering at home or with loved ones when it comes to your efforts to train, eat, and recover?

INTERESTS

How do you spend your time / what do you do for work?

What are your favorite hobbies (if you have any)?

What is your favorite thing about yourself (physical, mental, personality, etc.)?

What do you believe are your biggest strengths?

What fills you up and brings you joy?

Your Coaching

What drove you to seek out coaching?

What do you hope to get out of our coaching experience?

What do you expect from me as your coach?

Is there anything else you want to share that you haven't been asked yet?

Chose your preferred contact form by writing your availability below and a day when you are going to do your weekly check-ins.

Email
Text message
Messenger
What'sapp
Instagram message

Day:

Name: _____ Date: _____

Healthy Steps Exercise, Nutrition and Wellbeing Programme Consultation Form

Please fill in the forms to find out the best personalized exercise, nutrition and wellbeing programme for you .

A Goal setting

1. What is your general goal regard to your wellbeing?

_____

_____

2. Goals regards to your appearance: weight, body composition, slimmer, toned, muscular, bigger legs, slimmer waist, rounder shoulders, posture correction etc. Please circle which apply and write additionals.

_____

_____

3. Goals regard to your performances: improve fitness level, cardio, strength, flexibility, stress. It can be: I'd like to do 10 push ups, run 1K, do 30 mins hiit etc

_____

_____

4. By when would you like to achieve your goals? Different goals can have different dates. Please list each goals with by dates up to 1 year.

_____

_____

_____

_____

_____

5. Is there any weakness of yours what hold you back and strengths what can help you to achieve your goals?

_____

_____

If you are not sure about goal setting, please explain your difficulties here:

_____

_____

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B Weight managament: maintain, loss, gain, recomposition

1. Did you have any experience in any kind of weight management before?

2. Did you achieved your goal?

3. What is your reason to make changes now?

4. What kind of support do you need to achieve your goal?

5. What challenge you most? (Please circle or add others)

exercise nutrition time consistancy environment finance

sticking to a plan lack of knowledge about nutrition/exercise

health issues other commitments: work, family, pet

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C Nutrition: eating habits

1. Have you ever followed any special diet?
   Do you follow any now? Yes No
   If yes please give details:

2. Have you ever suffered from eating disorder, including stress and emotional eating?

3. What do you find most challenging regard to your eating habits?

4. Please list foods or food groups what you dislike

5. Please list your favourite foods, food groups

6. Do you count calories or macronutrients(carbohydrate, fat, protein)?

7. What kind of help would support you to achieve your goals?

Please complete 7 days food and drink diary.

MY WEEKLY FOOD AND DRINK DIARY

	BREAKFAST	LUNCH	DINNER	SNACKS	DRINK
MON	2 slices of white bread, toasted half avocado 3 slices of ham 200ml coffee with 2 tbs sugar and 50 ml milk	200 g chicken breast, 200 g pasta, 100 ml tomato passata, 50 g cheddar cheese	1 can of tuna with half can of sweetcorn, 1 spoon of mayonaise and natural yoghurt	1 medium apple and 20 pcs cashew	2 liter water
TUE					
WED					
THU					
FRI					
SAT					
SUN					

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D Exercise

1. What type of exercises do you like? (Please circle which apply and add others)
   body weight, ressistance training, weight training, dance, aerobic, tabata, hiit, boxercise, kick boxercice, yoga, pilates, barre, zumba, latin dance, streches, flexibility, mobility, body pump

2. Please list preferred workouts (for example squat)

3. Please list exercises what you dislike (for example burpee)

4. How active are you during the day?
   mostly sitting, mostly standing/ on feet, half and half, other:

5. Do you have any limitation to do a certain movements? (Please give details for example bad shoulders, time, financial problems)

6. What is your biggest barrier to exercising, being more active?

7. What kind of help would support you to achieve your goals?

Please complete 7 days activity and exercise diary.

Healthy Steps
ACTIVITY TIMETABLE

TIME	SUN	MON	TUE	WED	THU	FRI	SAT
7-8am	workout wiht free weights						
8-9	food prep plus breakfast tidy up						
9-12	housework, cleaning, washing, hoovering,						
12-14	cooking, washing up, tidy kitchen						
14-16	walk in a park						
16-17	dinner						
17-20	film watching, reading						
20-21	preparing to bed						
21	sleep						

Healthy Steps Exercise and Wellbeing Programme Consultation Form

E Stress, sleep, mood, energy

1. How would you rate your stress level and your controll over it? (1 is lowest and 10 is the highest)

2. How would you rate your sleeping quality? (1 is lowest and 10 is the highest)

3. How many hours of sleep usually do you have?

4. How would you rate your mood in general? (1 is lowest and 10 is the highest)

   Do you have any mood swings, changes during the day?

5. How would you rate your energy level? (1 is lowest and 10 is the highest)

   Is it different during the day, week?

6. Do you take any medication, supplements regard to stress, mood, energy?

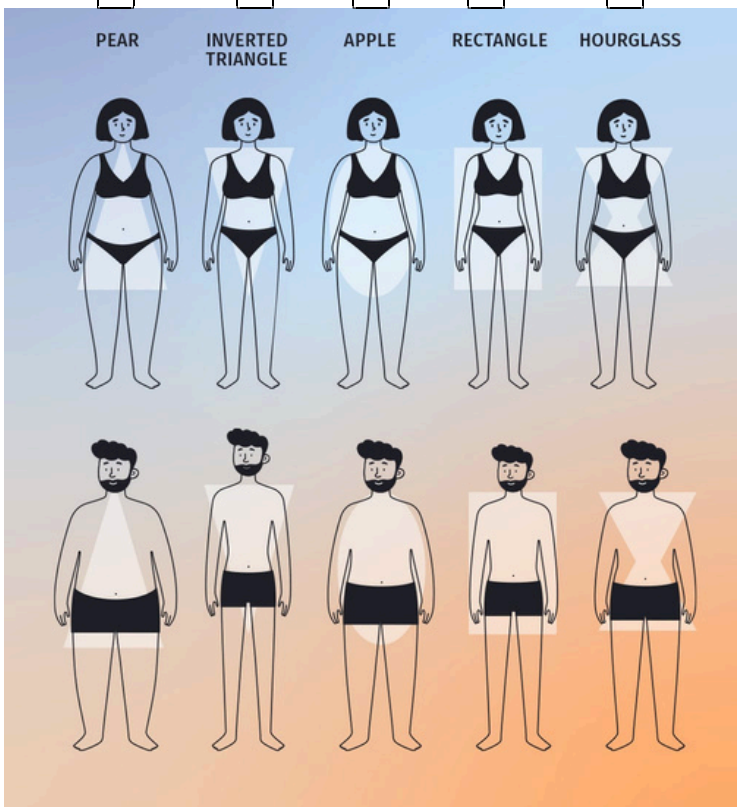
7. What kind of help would support you to make improvements?

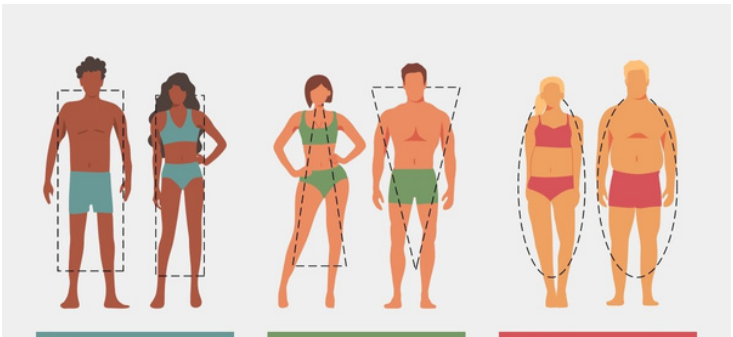
Healthy Steps Exercise and Wellbeing Programme Consultation Form

D Body type, composition

1 Please choose your body type.

☐ ☐ ☐ ☐ ☐

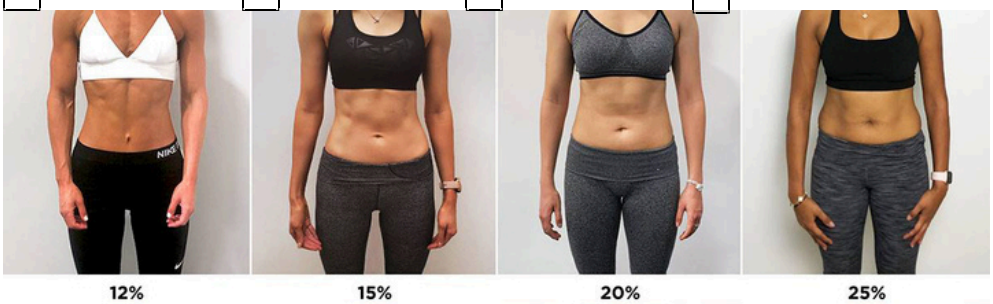




☐ ☐ ☐

2 Into which category would you place yourself?

☐ ☐ ☐ ☐



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