KANEHSATAKE CROSSFIT

NAME	
TELEPHONE #	
EMAIL	
HEIGHT	
WEIGHT	
BIRTHDAY	
OCCUPATION	
ADDRESS	

OBJECTIVE	
PREFFERED TIME OF DAY TO WORKOUT	Morning/Night Specific time:
COFFEE INTAKE	
ALCOHOL INTAKE	
DAILY WATER/SOFT DRINK INTAKE	
RESTAURANT/WEEK	
INJURIES IF YES DESCRIBE PAIN 1 TO 10	
ACCIDENTS? ANY TREATMENTS/PHYSIO?	
RESTRICTIONS	
DO YOU SMOKE	
MEDICAL HISTORY	
PRESCRIBED	

MEDICATION/SUPPLIMENTS	
PREVIOUS EXERCISE REGIMEN	
HOURS OF SLEEP/QUALITY	
BLOOD PRESSURE	HI/LOW/NORMAL
Would you be interested in nutrition services?	