

CLIENT ONBOARDING

Please fill out this detailed form and forward to
lil@otgathletic.co.za, marco@otgathletic.co.za and
rowan@otgathletic.co.za.



Fields marked with an asterisk are required*

GENERAL INFORMATION

Name & Surname*

Contact Number*

Email*

Age*

Height

Weight

Body Fat %

Marital Status*

Number of Children*

LIFESTYLE INFORMATION

What do you do for a living?*

How many hours per day do you work?*

How many days per week do you work?*

How long is your commute to work?*

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On a scale of 1-10, how would you rate your work stress?*

On a scale of 1-10, how would you rate your sleep?*

What is your quality of sleep like?*

TRAINING INFORMATION

What training methodologies have you followed in the past?*

(Pilates, Yoga, CrossFit, Powerlifting, Bodybuilding, etc.)

How many years have you been exercising?*

What are your biggest struggles or weaknesses with exercise?*

What are your physical goals, be objective, be specific, make them attainable,
we want to know everything about where you want to be physically? *

What gym will you be training at and what equipment will you have access to?*

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How many days per week are you able to train?*

How many hours per day can you dedicate to training?*

INJURIES · CONDITIONS · ILLNESS

Please list ALL injuries you have suffered with in the past, whether they be mild or major (inclusive of personal or sports related, i.e.: broken left femur sustained in car accident, sprained ankle from fall on stairs or torn rotator cuff from bench pressing). Please include any physical conditions you may suffer with, i.e.: scoliosis, spondylosis. Please include any illnesses you are currently suffering from, i.e.: arthritis, cancer, asthma, bulimia: *

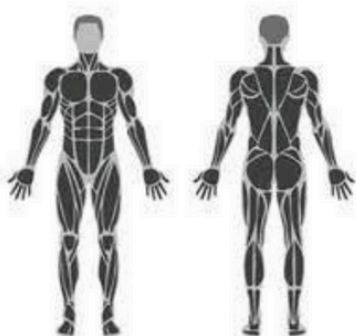
Do you have any musculoskeletal issues? Screenshot the below image, circle the below graphs as follows and upload in the button below if applicable:

Yes No

Current injury

Pain during/after activity

Past injury/trauma



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Give us some more information here: What caused the injury? Is it better or worse? What kind of pain do you experience (bruising/pinching/radiation)?
Give us a brief explanation on the above graph if applicable:

FLEXIBILITY TEST

Please complete this 9 point flexibility test. Score 1 if you are able to perform the movement, and 0 if you cannot:



Pull little finger back
beyond 90°
(One point for each side)

Left finger score*

Right finger score*



Pull thumb back to
touch forearm
(One point for each side)

Left thumb score*

Right thumb score*

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Bend elbow backwards
beyond 10°
(One point for each side)

Left elbow score*

Right elbow score*



Bend knee backwards
beyond 10°
(One point for each side)

Left knee score*

Right knee score*



Lie hands on the floor
while keeping knees straight
and bending forward at waist

Bend score*

Total score out of 90*

NUTRITIONAL ASSESSMENT

What are your physical goals?* (Weight loss, fat loss, muscle gain, performance)

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What diets have you followed in the past?*

Do you make use of steroids? If yes, list dosages.*

What supplements do you currently use?*

Are you currently on any medications?*

Do you have a menstrual cycle?*

Yes No

Is your cycle regular?*

Yes No

Do you consume alcohol? If so, how often?*

What are your religious practices? *

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Do you have any food allergies? * Please list all.

What are your food preferences? (Vegetarian, vegan, pescatarian, etc.)

What do you struggle most with nutritionally?*

Are you a very social person (enjoy frequent social events)? *

Do you have any foods that trigger you or foods that you just cant say no to? *

What foods are your least favorite? *

What do you prefer when dieting? Low carb or high fat or what are your preferences and tell us why: *

Do you suffer with any digestive issues like IBS? *

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What is your relationship with food like? Do you see some foods as good or bad*

Do you prefer carbs or fats? For example do you immediately reach for starchy food (bread) or fattier food (cheese): *

Do you have any history with food dysmorphia or body image dysmorphia (you see yourself as bigger or smaller than you actually are or a fixation on the number on the scale): *

Will you be doing any training or exercising, additional training outside of what you are being prescribed by OTG? If so, please detail: *

How many steps are you currently getting in a day according to your tracker, if you are tracking? *

Have you had any blood work done in the last 12 months? Yes/No. If so, please could you send your results with this form.

Please could you complete a 48 hour dietary recall of the last 2 days: *

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How many meals plus snacks do you prefer in a day?*

Measure circumference of relaxed bicep at exact midpoint between shoulder bone and elbow. Measure both left and right and side and complete below for example "Left 30cm, Right 30cm":

Left:

Right:

Measure circumference of widest part of chest, directly over the nipple for example "30cm":

Measurement:

Measure the circumference of waist, directly over belly button for example "30cm":

Measurement:

Measure the circumference of hips, directly over widest part of bum for example "30cm":

Measurement:

Measure the circumference of thighs, directly around widest part of thigh.

Measure both left and right and side and complete below for example "Left 30cm, Right 30cm":

Left:

Right:

Measure the circumference of calves, directly around widest part of calf. Measure both left and right and side and complete below for example "Left 30cm, Right 30cm":

Left:

Right:

What is your bodyweight first thing in the morning?

What is your bodyweight just before bed?

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Forward 3x full-length photos showing your front, side, and back, holding today's newspaper for date reference. Please wear only a sports bra, bikini top, or bra, and bikini bottoms or tight shorts.

Thank you for taking the time to complete this form.

We appreciate the effort you've put in. Your responses allow our team to create a plan that's truly tailored to you.

Please email the completed form to:

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We're excited to get started with you.