Health History, Exercise, and Lifestyle Questionnaire

_Today's Date _____/_____/_____

Name _____

Gender: M F DOB ____/____/____ Age ____

Mailing Address _____

_____

Email _____

Home Phone (_____) ____-_____ Cell (_____)____-_____

Emergency Contact Person _____

Phone (_____) ____-_____

THANK YOU FOR TAKING TIME TO COMPLETE THIS QUESTIONNAIRE. Please answer each question carefully and completely. This is very important information and will contribute significantly to the development and implementation of your personal health and/or fitness program. If you have any questions please do not hesitate to ask your coach.

PART 1 – Medical History

Have you seen a doctor for anything in the last 12 months? If so then what had happened?

Are you currently taking any medications, if please list

Health History, Pre Exercise, and Lifestyle Questionaire

Do you take any nutritional/dietary supplements? If so please list below.

Do you now have or in the past suffered from any of the following? :
a. Has your Doctor said or do you have a history of heart problems, chest pain or stroke YES / NO
b. Has an immediate family member (parent/sibling) had a heart attack, stroke or cardiovascular disease before the age of 55 yrs old? YES / NO
c. Do you frequently have pains in your heart and/or chest when you do physical activity? YES / NO
d. Do you lose balance because of dizziness or do you ever lose consciousness? YES / NO
e. Is our doctor(s) currently prescribing drugs for blood pressure or heart condition? YES / NO
f. Are you over the age of 65 and not accustomed to vigorous exercise? YES / NO
g. High Cholesterol or HDL:LDL imbalance YES / NO
h. Do you currently smoke? Cigarette, cigar, pipe smoking YES / NO
If So Then How Much _____ How Long _____
i. Obesity YES / NO
j. Asthma or Breathing trouble YES / NO
k. Have you ever had a stroke or heart attack? YES / NO
l. Are you a male greater than 45 yrs old? Are you a female greater than 55 yrs old? YES / NO
m. (Females) Pregnancy currently or within last 12 months YES / NO
n. Learning disabilities or cognitive challenges YES / NO
o. Is there any reason not mentioned thus far to preclude you from regular exercise activity? YES / NO

PART 1 – Medical History

Do you have any diagnosed diseases, such as:
Orthopedic (spinal fusion, knee/hip replacement?
Metabolic (Diabetes, Hypothyroid)
Neurological (Stroke, Parkinson)

Do you have any occupational stressors? (Physical). Sitting, Standing, Positional
How long are you under stressor?

Health History, Pre Exercise, and Lifestyle Questionaire

If you feel that you are experiencing unusual levels of stress in one or more of the following areas. Please circle ‘Yes” if not circle “No”:

Home	Yes	No
Work	Yes	No
Financial	Yes	No
Relational	Yes	No

Elaborate if you’d like.

What self-care strategies do you currently use to manage your own health and why? (Ice packs, stretching, acupuncture, magnets, heating pad, massage, etc.)

Health History, Pre Exercise, and Lifestyle Questionaire

PART 2 - Fitness History

Have you consulted with a physician regarding diet and exercise? If yes, please describe the recommendations.

Have you in the past, or are you currently following a special diet or eating program? Please describe.

What if any, changes would you like to make to your current eating habits?

Please describe your current exercise program include;
How often -
How long is each session -
Type of exercise -
Method of exercise -
Where do you exercise –
Level of enjoyment -

Health History, Pre Exercise, and Lifestyle Questionaire

How long have you participated in regular exercise programs?

Do you currently have or in your past worked with a fitness professional/trainer/coach?

Do you own any exercise equipment? Please list.

Have you ever got hurt exercising? Explain.

What are the possible reasons you would not complete your training program and embrace exercise as a lifelong, lifestyle, process?

Health History, Pre Exercise, and Lifestyle Questionaire

What's your energy level like first thing in the morning on a scale of 1-10?
1 2 3 4 5 6 7 8 9 10

Middle of the day?
1 2 3 4 5 6 7 8 9 10

How would you like to be rewarded, and what is the basis for the reward, when you reach your set goals?

PART 3 - Lifestyle History

How do you incorporate family and friends into your fitness lifestyle?

What stress management strategies work well for you?

Health History, Pre Exercise, and Lifestyle Questionaire

Tell me about how you keep your commitment to yourself and to others.

What do you to “recharge” and “restore” yourself when you need to?

PART 4 – Your Vision

What's your ideal fitness lifestyle look and feel like. Also include tangible measurable benchmarks, ie 1 mile run time, blood pressure, etc.

3 month Vision

a. 1-10 level of fitness =

b. What 1 word would describe how it would feel to be that fit and live the lifetstyle that supports and accomplishes that level of fitness?

c. 1-10 desired energy level =

d. Top 3 Measurable goals

i.

ii.

iii.

Health History, Pre Exercise, and Lifestyle Questionaire

e. What 1 positive habit added would have the biggest impact?

f. What 1 negative habit eliminated would have the biggest impact?

g. What would you accomplish or do that makes you feel fully alive?

h. Are you playing any sports? Trying new sports?

i. Are you going on any fitness related field trips and/or adventures?

j. Do you have a “checklist’ of events, benchmarks and/or experiences that you’d like to accomplish?

k. Other.

Health History, Pre Exercise, and Lifestyle Questionaire

What does your perfect morning ritual look like?

a. What do you eat?

What does your perfect evening ritual look like?

a. What time do you go to sleep? Do you read, watch TV, journal, etc...