

CONFIDENTIAL HEALTH AND LIFESTYLE QUESTIONNAIRE

Name _____
Address _____
Home telephone _____
Work telephone _____
Mobile _____
Email _____
Occupation _____
Date of birth _____

Doctor's name _____
Address _____
Telephone _____

Emergency contact _____
Relationship _____
Home telephone _____
Work telephone _____
Mobile _____

HEALTH QUESTIONNAIRE

Have you, or do you suffer from any of the following?

Asthma <input type="checkbox"/>	Constipation <input type="checkbox"/>	Rheumatic fever <input type="checkbox"/>
Angina <input type="checkbox"/>	Diabetes <input type="checkbox"/>	High cholesterol <input type="checkbox"/>
High blood pressure <input type="checkbox"/>	Frequent colds <input type="checkbox"/>	Palpitations <input type="checkbox"/>
Low blood pressure <input type="checkbox"/>	Dizziness/fainting <input type="checkbox"/>	Headaches <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Heart disease <input type="checkbox"/>	Migraines <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Shortness of breath <input type="checkbox"/>	Joint pains <input type="checkbox"/>

Please provide details where applicable. _____

Have any of your first-degree relatives experienced the following conditions?

Heart attack <input type="checkbox"/>	Heart operation <input type="checkbox"/>	Congenital heart disease <input type="checkbox"/>	High cholesterol <input type="checkbox"/>
---------------------------------------	--	---	---

Have you ever had surgery? Yes No
If yes, give details.

Please list any injuries you've had in the past, i.e., broken bones, sprains, etc.

Do you have tension or soreness in a specific area?
If yes, give details. Yes No

Do you experience numbness, tingling or stabbing pains anywhere?
If yes, give details. Yes No

Are you sensitive to touch/pressure in any area?
If yes, give details. Yes No

Do you experience stiff, swollen or painful joints?
If yes, give details. Yes No

What is your "chief complaint"?

Date of onset and duration

What incident do you feel may have caused the problem?

Treatment to date

Previous diagnoses

Does your "chief complaint" affect you on a day-to-day basis?
If yes, give details. Yes No

Are the symptoms brought on by certain activities?
If yes, give details. Yes No

Do specific activities or positions alleviate your symptoms?
If yes, give details. Yes No

When is the pain worse?

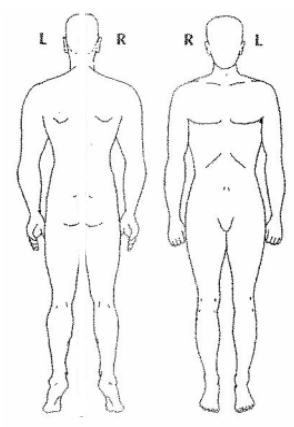
Do you experience fatigue or lack of energy?
If yes, give details. Yes No

What is your current weight?

Have you had any of the following: physical therapy, osteopathy, massage therapy, other? *If yes, please elaborate.* Yes No

Please list any medications you are currently taking.

Indicate on the diagrams where you have been experiencing pain.



LIFESTYLE QUESTIONNAIRE

Occupation; please explain your position along with the physical and mental responsibilities involved.

Do you have an ergonomically set up desk/workstation? Yes No

How many hours do you spend in front of a computer?

How much time do you spend in a seated position?

On a scale of 1-10 (1=not active, 10=very active), please rate how active you are on a daily basis.

1 2 3 4 5 6 7 8 9 10

How often do you take part in physical exercise?

7+ times/week 5-6 times/week 3-4 times/week 1-2 times/week

How long have you been consistently physically active for?

What activities are you presently involved in?

Cardio/Sports	Frequency/week	Average length	Easy/Moderate/Hard
---------------	----------------	----------------	--------------------

Strength Training	Frequency/week	Average length	Easy/Moderate/Hard
-------------------	----------------	----------------	--------------------

Stretching	Frequency/week	Average length
------------	----------------	----------------

Please check all the activities that interest you:

- | | | |
|--|--|---|
| Aerobic fitness class <input type="checkbox"/> | Kayaking <input type="checkbox"/> | Soccer <input type="checkbox"/> |
| Baseball <input type="checkbox"/> | Partner training <input type="checkbox"/> | Swimming <input type="checkbox"/> |
| Basketball <input type="checkbox"/> | Pilates <input type="checkbox"/> | Tennis <input type="checkbox"/> |
| Boxing <input type="checkbox"/> | Private personal training <input type="checkbox"/> | Triathlon <input type="checkbox"/> |
| Football <input type="checkbox"/> | Racquetball <input type="checkbox"/> | Volleyball <input type="checkbox"/> |
| Golf <input type="checkbox"/> | Rock climbing <input type="checkbox"/> | Walking <input type="checkbox"/> |
| Group personal training <input type="checkbox"/> | Running <input type="checkbox"/> | White water rafting <input type="checkbox"/> |
| Hiking <input type="checkbox"/> | Skiing <input type="checkbox"/> | Yoga <input type="checkbox"/> |
| Ice skating <input type="checkbox"/> | Snowboarding <input type="checkbox"/> | Other, specify below <input type="checkbox"/> |
| Indoor cycling <input type="checkbox"/> | Snowshoeing <input type="checkbox"/> | |

How many hours sleep do you get everyday?

Do you consider yourself to be under stress?
If yes, give details.

Yes No

Do you smoke?
If yes, how many per day.

Yes No

Do you drink alcohol?
If yes, how many units per week.

DIET QUESTIONNAIRE

Do you follow, or have you recently followed, any specific dietary intake plan?
If yes, give details

Yes No

In general, how do you feel about your nutritional habits?

Daily Dietary Intake

No. of cups of coffee _____
 No. of cups of tea _____
 Glasses of coke/soda _____
 Glasses of milk _____
 Glasses of water _____
 Bread, pasta _____

Amount of sugar _____
 Chocolates _____
 Sweets _____
 Alcohol _____
 Portions of fruit _____
 Portions of vegetables _____

Food Diary Snapshot

Breakfast	_____	Time	_____
Snack	_____	Time	_____
Lunch	_____	Time	_____
Snack	_____	Time	_____
Dinner	_____	Time	_____
Snack	_____	Time	_____

GOAL QUESTIONNAIRE

Please list THREE goals in order of importance:

1. _____
2. _____
3. _____

Where are you now in relation to your goals?

1. _____
2. _____
3. _____

What is the biggest challenge you must overcome to attain your goal?

- | | | |
|--|--|---|
| Lack of interest/motivation <input type="checkbox"/> | Procrastination <input type="checkbox"/> | Lack of time <input type="checkbox"/> |
| Injury <input type="checkbox"/> | Lack of ability/fitness <input type="checkbox"/> | Lack of facilities <input type="checkbox"/> |
| Financial cost <input type="checkbox"/> | Family responsibility <input type="checkbox"/> | Medical Advice <input type="checkbox"/> |
| Low self-esteem <input type="checkbox"/> | Other, specify <input type="checkbox"/> _____ | |

On a scale of 1-10 (1=not committed, 10=very committed), please rate how committed you are to your goals.

1 2 3 4 5 6 7 8 9 10

List three tasks you can do to pave the path toward total achievement.

1. _____
2. _____
3. _____

Have you ever had a personal trainer?

Yes No

If yes, give details of when and for how long

How did you find out about my services?

- | | | |
|--|---------------------------------------|---|
| Brochure <input type="checkbox"/> | Yellow pages <input type="checkbox"/> | Magazine article <input type="checkbox"/> |
| Newspaper <input type="checkbox"/> | Website <input type="checkbox"/> | Newsletter <input type="checkbox"/> |
| Referral, specify <input type="checkbox"/> _____ | Gym <input type="checkbox"/> _____ | |

Why did you choose to train with my organisation?

- | | | |
|---|--|--|
| Word of mouth <input type="checkbox"/> | Quality of programs <input type="checkbox"/> | Personal trainers <input type="checkbox"/> |
| Location <input type="checkbox"/> | Cost <input type="checkbox"/> | Credibility <input type="checkbox"/> |
| Other, specify <input type="checkbox"/> _____ | | |

All the information on this form is correct and to the best of my knowledge. I have sought and followed any necessary medical advice.

Signature _____

Print name _____

Date _____