

Health, Wellness, and Lifestyle Questionnaire



A Division of Island Fitness Express, INC.

Name: _____ Sex: _____

Address: _____ City/Zip: _____

Birthday: _____ Age: _____

Email: _____ Phone: _____

Physician's Phone: _____ Cell Phone: _____

Physician's Name: _____

Date of Last Physical: _____

The enclosed information is required to assess your physical fitness level and to establish your exercise prescription. Your health questionnaire and test results are confidential and will not be released to anyone other than yourself.

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Trainer: _____

Date Completed: _____

Please rate your current life stress level: Very _____ Mildly _____ Periodically _____ No Stress _____

Do you diet? *(If yes why?)*

Weight Loss _____ Weight Gain _____ Medical _____

Explanation _____

Do you feel your current diet is successful? _____

What type of diet are you currently trying? _____

What types of diets have you tried in the past? _____

Were they successful or unsuccessful and why? _____

Do you currently or have you in the past suffered from an eating disorder? *(If yes please explain)* _____

Please describe your current eating habits including time and food.

Morning: _____

Snack: _____

Mid-Day: _____

Snack: _____

Evening: _____

Estimated number of glasses of water consumed daily: _____

Under what circumstances do you tend to overeat or eat foods you know that you shouldn't? _____

Please list your current participation in physical activities:

What: _____

Times per week _____ Minutes per session _____

What usually interrupts your work out plans?

How long do you usually stick with a work out program?

How much time can you devote to your work out program?

Days per week _____ Minutes per day: _____

What types of exercise interest you?

- | | | |
|-----------------|----------------------------|-------------------|
| Walking | Stationary Bike | Jogging/Running |
| Rowing | Swimming | Cycling |
| Tennis | Aerobics | Strength Training |
| Flexibility | Crosstraining | Par Courses |
| Elliptical | Water Aerobics | Dancing |
| Gardening | Stationary | Cardio Training |
| Sports Training | Yoga | Pilates |
| Kickboxing | Other <i>(please list)</i> | |

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Have you ever experienced any of the following while walking, working, or exercising?

Pain in the chest
No Yes _____
Pain in the neck
No Yes _____
Pain in the lower back
No Yes _____
Abnormal shortness of breath
No Yes _____
Faintness or light headedness
No Yes _____
Confusion or dizziness
No Yes _____
Leg pain
No Yes _____
Heart beat irregularities
No Yes _____
Persistent cough
No Yes _____

Have you recently experienced any of the following:

Localized muscle soreness
No Yes _____
Joint stiffness
No Yes _____
Flair-up of old injuries
No Yes _____
Loss of local muscle strength
No Yes _____
Noticeable loss of muscle size
No Yes _____
Restricted joint movement
No Yes _____

Do you take medication on a regular basis?

(if yes please list)

Prescription _____ Non-Prescription _____

Please list any past surgery, injury, pregnancy or serious illness and the date each occurred.

To your knowledge do you have or have you had any of the following? Or is there a family history?

Diabetes
No Yes _____
Heart/Cardiopulmonary Disease
No Yes _____
Heart Murmur, Angina, Heart Attack, Coronary, Athleroscleroses or Pulmonary Disease
No Yes _____
Asthma, Emphysema, Bronchitis, Gout (elevated uric acid)
No Yes _____
Thyroid, Kidney or Liver Disease
No Yes _____
Stroke
No Yes _____
Rheumatic Fever
No Yes _____
Anemia-low red blood cell count
No Yes _____
Hernia
No Yes _____
Varicose Veins
No Yes _____
Aids or HIV positive
No Yes _____

****trainer be sure to transfer information to risk factor worksheet.**

Has your personal physician indicated that you have:

High Blood Pressure
No Yes *(please indicate Systolic or Diastolic)* _____
Elevated Blood Cholesterol
No Yes *(please indicate level)* _____
Family history of either of the above?
No Yes _____

Do you smoke a pipe, cigars or cigarettes?

(if yes please complete the following:)

per day _____ # of years _____

If you have smoked, how long since you quit? _____

Do you consume alcoholic beverages?

(If yes please complete the following:)

Daily _____ Weekly _____ Monthly _____

Average Hours of Sleep per night? _____

Occupation _____

Hours Worked per Week _____

Please list your current fitness goals in each category that applies and then number 1 to 6 in priority of importance to you, 1 being the most important.

Health # _____ Weight loss/gain # _____

Sports Performance # _____ Appearance/body # _____

Job Performance # _____ Special Occasion # _____

Risk Factor Quiz

Age <ul style="list-style-type: none"> • older than 45 years and male gender • older than 55 years and female gender • premature menopause in female younger than 55 years without estrogen therapy 	+1
Family History <ul style="list-style-type: none"> • father or first degree relative younger than 55 with MI or sudden death • mother or first degree relative younger than 65 with MI or sudden death 	+1
Current Cigarette Smoking	+1
Hypertension <ul style="list-style-type: none"> • blood pressure greater than 140/90mm HG confirmed on 2 occasions • currently taking antihypertensive medications 	+1
Hypercholesterolemia <ul style="list-style-type: none"> • total serum cholesterol greater than 200 mg/dl • or HDL less than 35 mg/dl • or TC/HDL greater than 5.0 	+1
Diabetes Mellitus <ul style="list-style-type: none"> • older than 30 years with insulin dependent diabetes • insulin dependent diabetes for more than 15 years • older than 35 years with non-insulin dependent diabetes 	+1
Sedentary Lifestyle <ul style="list-style-type: none"> • no regular physical activities • no active recreational pursuits • inactive job – majority of time is spent sitting 	+1
Total Points	



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How ready are you to succeed?

There are six stages of change: Pre-contemplation, Contemplation, Preparation, Action, Maintenance, Termination—and the cycle starts over from there... As you can tell, there are three that need to take place before even your first action happens. Obviously, change has to come from you—If you believe—if it is going to be, it is up to me. Answer the following questions honestly and see how ready you are for the fourth step – **ACTION**.

Do you believe that you are at some sort of health risk because of your current behaviors/lifestyle?	YES	NO
Do you feel that making lifestyle changes will improve your quality of life and decrease your risk of health-related disorders?	YES	NO
Do you view lifestyle change as a lifetime goal rather than a short-term temporary goal?	YES	NO
Are you willing to get personally involved in planning a lifestyle change program?	YES	NO
Are you willing to try different approaches?	YES	NO
Do you have the patience to accept success in small increments and deal with possible setbacks?	YES	NO
Are you willing to set realistic goals?	YES	NO
Are you willing to make lifestyle changes and not make another “false start?”	YES	NO

Let's see how motivated you are!

Do you want this to be the last time you start an exercise program?

	Not really			Very	
	1	2	3	4	5
Compared to previous attempts, how motivated are you at this time to try to change your lifestyle?	1	2	3	4	5
How certain are you that you will stay committed to the program for the time it will take you to reach your goal?	1	2	3	4	5
Considering all outside factors at this time in your life (stress at work, family obligations, etc.) to what extent can you tolerate the effort required to stick to a lifetime exercise and nutrition plan?	1	2	3	4	5
Think honestly about how much you hope to achieve and in what timeframe. How realistic are your expectations?	1	2	3	4	5
How confident are you that you can work regular exercise into your daily schedule starting tomorrow?	1	2	3	4	5

Your Score: (1-10) Low Motivation (11-20) Moderate Motivation (20+) High Motivation

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New Habits Checklist

Basic Recommendations and Guidelines for Your New Lifestyle.

Laws of Success:

Law of Possession - "If it's to be, it's up to me."

Law of Effort - "Anything worth achieving is worth working for."

Law of Consistency - "I have to stick with the game plan."

Law of Self Efficacy - "If I think I can or I think I can't. I'm probably right."

Cardiovascular Training

Resistance Training

Flexibility Training

Nutrition and Eating Habits

Goals

1)

2)

3)

Your first appointment is _____ with _____

Voicemail Number _____ ext. _____ E-mail _____

Name: _____

AGENTS OF CHANGE