

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.

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 *(please list)*

AGENTS OF CHANGE

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	