Fountain View FITNESS

Personal Training | Lifestyle & Health History Questionnaire

Last Name ______________________ First Name ______________________

Date ______________________ DOB ______________________

Medical Information

How would you describe your present state of health?

- ☐ Very well
- ☐ Healthy
- ☐ Unhealthy
- ☐ Unwell
- ☐ Other

List current medications, how often you take them, and dosages

Include prescriptions and over-the-counter medications

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____

Do you take all of your medications as they have been prescribed by your healthcare provider?

- ☐ Yes
- ☐ No

If not, please share why.

e.g., cost, side effects, or feeling as though they are unnecessary

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Do you take any vitamin, mineral, or herbal supplements?

- ☐ No
- ☐ Yes

If yes, list type and amount per day.

____

____

Check any that apply to you and list any important information about your condition:

- ☐ Allergies
- ☐ Amenorrhea
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Celiac Disease
- ☐ Chronic Sinus Condition
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Disordered Eating
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Hypo/hyperthyroidism
- ☐ Insomnia
- ☐ Intestinal problems
- ☐ Irritability
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Menopausal Symptoms
- ☐ Osteoporosis
- ☐ Premenstrual Syndrome (PMS)
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Pregnant
- ☐ Skin Problems
- ☐ Ulcer
- ☐ Major Surgeries
- ☐ Past Injuries
- ☐ Other

Allergies
specify

____

____

Past Injuries
specify

____

____

Other Health Conditions not mentioned above.
specify

____

____

Nutrition

Have you ever followed a modified diet?

- ☐ *No*
- ☐ *Yes*

If yes, describe

____

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Are you currently following a specialized eating plan?
e.g., low-sodium or low-fat

- ☐ *No*
- ☐ *Yes*

If yes, what type of eating plan?

Why did you choose this eating plan?

Was the eating plan prescribed by a physician?

- ☐ *No*
- ☐ *Yes*

How long have you been on the eating plan?

Have you ever met with a registered dietitian?

- ☐ *Yes*
- ☐ *No*

If no, are you interested in doing so?

- ☐ *No*
- ☐ *Yes*

How many glasses of water do you drink per day?
8-ounce glasses

What do you drink other than water?
8List what and how much per day.

Do you have any food allergies or intolerance?

- ☐ *No*
- ☐ *Yes*

If yes, what?

How often do you dine out?
times per week

Substance-related Habits

Do you drink alcohol?

- ☐ No
- ☐ Yes

If yes, how often?
times per week

Average amount?

Do you drink caffeinated beverages?

- ☐ No
- ☐ Yes

If yes, average number per day

Do you use tobacco?

- ☐ No
- ☐ Yes

If yes, how much
cigarettes, cigars, or chewing tobacco per day

Physical Activity

How many minutes of cardiorespiratory activity per week?

How many minutes of muscular-training sessions per week?

How many minutes of flexibility-training sessions per week?

How many minutes of sports or structured recreational activities per week?

List sports or activities you participate in:

Have you ever experienced any injuries that may limit your physical activity?

- ☐ No
- ☐ Yes

If yes, describe

Do you have any physical-activity restrictions?

- ☐ No
- ☐ Yes

If so, please list

What are your honest feelings about exercise/physical activity?

What are some of your favorite physical activities?

Occupational

What is your occupation?

What is your working routine?

- ☐ Stay at home parent
- ☐ Commute to office
- ☐ Work from home
- ☐ Hybrid working routine
- ☐ Retired

What is your work schedule?

Describe your activity level during the work day

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Sleep & Stress

How many hours of sleep do you get at night?

Rate your average stress level
from 1 (no stress) to 10 (constant stress)

What is most stressful to you?

How is your appetite affected by stress?

- ☐ Increased
- ☐ Not Affected
- ☐ Decreased

Goals

How many hours of sleep do you get at night?

On a scale of 1 to 10, how likely are you to adopt a healthier lifestyle
1 = very unlikely; 10 = very likely

Do you have any specific goals for improving your health?

- ☐ No
- ☐ Yes

If yes, please list them in order of importance.

Do you have a weight-loss goal?

- ☐ No
- ☐ Yes

If yes, what is it?

Why do you want to lose weight?