Lifestyle and Health History Questionnaire

CLIENT PERSONAL INFORMATION

Name: _____ Date: _____

Age: _____ Gender: _____ Height: _____ Weight: _____

Physician Name and Phone #: _____

Emergency Contact Name and Phone #: _____

EXERCISE
What exercise activities do you currently take part in (e.g., running, weightlifting, group exercise, etc.)? _____
How many days per week do you get at least 60 minutes of moderate-intensity exercise? _____
On a scale of 0 to 10, how important are the following fitness goals to you? Weight loss: _____ Muscle gain: _____ Sports performance: _____ Health improvement: _____

DIET
On a scale of 0 to 10, do you consider your overall diet to be healthy? _____
Are you currently following any kind of diet? If so, what diet and for what reason(s)? _____
How would you rank your daily salt intake: low, medium, or high? _____
How would you rank your daily sugar intake: low, medium, or high? _____
How would you rank your daily fat intake: low, medium, or high? _____
On a scale of 0 to 10, how effectively are you able to control your temptations for junk food? _____
How many alcoholic drinks do you consume per week? _____

Lifestyle and Health History Questionnaire

Do you consume caffeinated beverages such as coffee, tea, soda, and/or energy drinks? How many per week?

_____

LIFESTYLE

Do you feel like you get enough sleep and wake up feeling rested each day?

_____

On a scale of 0 to 10, how would you rate your average level of stress?

_____

What techniques do you currently use to manage your stress levels?

_____

Do you smoke tobacco or use a vaporizer alternative?

_____

OCCUPATION

What is your occupation?

_____

Does your occupation require extended periods of sitting? (If YES, please explain.)

_____

Does your occupation require repetitive movements? (If YES, please explain.)

_____

Does your occupation require you to wear shoes with a heel (e.g., dress shoes, work boots)?

_____

RECREATION

Do you partake in any recreational physical activities (golf, skiing, etc.)? (If YES, please explain.)

_____

Do you have any additional hobbies (gardening, fishing, music, etc.)? (If YES, please explain.)

_____

MEDICAL

Please list out any past musculoskeletal injuries:

_____

Please list out any past surgeries:

_____

If you have experienced injuries or surgeries, were they properly rehabilitated and did you receive clearance from a doctor to return to physical activity?

_____

Do you have any chronic health conditions (such as, but not limited to, cardiovascular disease, pulmonary disorders, hypertension, diabetes, or cancer)? (If YES, please explain.)

_____

Are you on any medications, and if so, have you received clearance from your doctor to take part in physical activity?

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Additional Notes:

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