**WELLNESS COACHING**

**CLIENT QUESTIONNAIRE**

**GENERAL INFORMATION**

Name: Date:

Street Address:

Phone:

E-mail:

Occupation:

Employer:

Date of Birth:

Age:

Sex:

Children (# and ages):

Relationship Status:

**GOALS, GENERAL HEALTH HISTORY, BACKGROUND**

Body Weight: Current Body Weight:

 Goal Body Weight:

 One Year Ago:

 Two Years Ago:

 Five Years Ago:

 Ten Years Ago:

Frame Size (if known): Small Medium Large

Height: \_\_\_\_\_ Feet \_\_\_\_\_Inches

Fitness Goals Priority: 1 2 3

Nutrition Goals Priority: 1 2 3

Weight Goals Priority: 1 2 3

Stress Management Priority: 1 2 3

Health Goals Priority: 1 2 3

Other Goals Priority: 1 2 3

Check goals and add details, if necessary:

\_\_\_ Weight-management \_\_\_\_\_\_ lbs

\_\_\_ Increased energy/Productivity

\_\_\_ Improved appearance

\_\_\_ Feel/look younger

\_\_\_ Improved muscle tone

\_\_\_ Improved muscle mass

\_\_\_ Decreased stress

\_\_\_ Better sleep

\_\_\_ Improved self esteem

\_\_\_ Decreased depression

\_\_\_ Decreased alcohol consumption

\_\_\_ Decreased tobacco consumption

\_\_\_ Improvement of one or more medical conditions

\_\_\_ Improved relationships

What else do I need to know to help you reach your goals?

What is the first area you would like to work on with your coach?

How would you describe your ideal personal coach?

What are your scheduling preferences (days and times you are most available)?

Additional comments:

**PHYSICAL ACTIVITY**

Describe your current level of activity:

Describe any fitness programs or physical activities you have engaged in during the last 10 years and describe the results and lessons, if any, were learned:

Current limitations on physical activity (e.g., knee injury prevents walking):

Previous limitations on physical activity (over the last 10 years):

Do you currently engage in any of the following exercise programs or activities?

\_\_\_ Aerobics (fast walking, jogging, biking, etc.)

\_\_\_ Stretching

\_\_\_ Strength Training (weight lifting)

\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your exercise routine in the past week:

Describe type and minutes or hours of weekly recreational physical activities (such as social dancing, gardening, yard work, walking from train station to job):

Describe efforts to incorporate more activity in daily life (such as taking the stairs instead of the elevator; parking once for errands and then walking):

Physical activities enjoyed most:

Physical activities you enjoyed as a child or younger adult:

Physical activities you dislike:

Physical activities you would like to try:

Please list fitness equipment you own:

Describe how you use that equipment or used it in the past:

Do you currently belong to a health club or regularly participate in classes:

**NUTRITION**

Typical weekday meals: Breakfast

 Lunch

 Dinner

 Snacks

Typical weekend meals: Breakfast

 Lunch

 Dinner

 Snacks

Time of day snacks are eaten: \_\_\_ Morning

 \_\_\_ Mid-morning

 \_\_\_ Afternoon

 \_\_\_ Mid-afternoon

 \_\_\_ Evening

 \_\_\_ Late night

Daily liquid intake (# of 8-ounce glasses typically consumed each day):

 Non-alcoholic: \_\_\_ Water

 \_\_\_ Milk (circle % fat: 0% 1% 2% 4% half & half)

 \_\_\_ Juice or Sports Drinks

 \_\_\_ Diet Soda

 \_\_\_ Regular Soda

 \_\_\_ Regular Coffee

 \_\_\_ Decaf Coffee

 \_\_\_ Regular Tea

 \_\_\_ Decaf Tea

 \_\_\_ Herbal Tea

 \_\_\_ Other

 Alcoholic Weekday: \_\_\_ Beer

 \_\_\_ Wine

 \_\_\_ Liquor

 Alcoholic Weekend: \_\_\_ Beer

 \_\_\_ Wine

 \_\_\_ Liquor

List your favorite foods:

List the foods you dislike:

Describe your intake of fast foods and processed foods:

List any vitamins and supplements you are currently taking and their effect on your health:

How often do you eat in restaurants in a typical week, and what type of restaurants do you go to?

What do you typically eat at restaurants?

List any weight-management program tried in the last 10 years:

Describe any food allergies and prohibitions (e.g., no red meat, lactose intolerance):

What dietary habits would you like to change?

**ENERGY LEVEL AND METABOLISM**

Last foods typically consumed before peak energy time:

Last foods typically consumed before lowest energy time:

Time of day when energy level is highest:

Time of day when energy level is lowest:

Describe digestive problems, if any:

Likely cause of digestive problems, if known:

Foods that give you the highest short-term energy boost:

Foods that make you sluggish:

**STRESS MANAGEMENT**

Describe your general level of stress: Low Medium High

Describe the impact daily stress has on your health: Low Medium High

Describe in detail your typical weekday schedule (time you wake up, work schedule, evening activities):

Describe in detail your typical weekend schedule (time you wake up, evening activities):

How do you feel when you wake up most mornings?

How do you feel when you go to sleep most nights?

Describe sleep problems:

Describe likely cause of sleep problems:

Describe and rank the things that cause you the greatest stress:

Describe the measures to reduce stress in your life that you have tried over the past ten years, and the results and lessons learned:

Are you willing to participate in stress-reduction activities? Yes No Maybe

Describe the activities that give you the most enjoyment, satisfaction, or sense of well-being:

Describe any other obstacles to improving your health that you believe you have:

**MEDICAL HISTORY**

Do you ever experience an irregular or racing heart rate during exercise or at rest?

Are you pregnant?

Are you over the age of 65 and not accustomed to vigorous exercise?

Has a doctor ever said that your blood pressure is too high?

Is there a good reason not mentioned above why you should not follow an activity program?

If yes, please explain:

Do any of the following conditions exist currently or in the past?

 Taking Medication Under Control Family History

High cholesterol \_\_\_\_ \_\_\_\_ \_\_\_\_

Low HDL/LDL ratio \_\_\_\_ \_\_\_\_ \_\_\_\_

Atherosclerosis \_\_\_\_ \_\_\_\_ \_\_\_\_

Angina \_\_\_\_ \_\_\_\_ \_\_\_\_

Compulsive overeating \_\_\_\_ \_\_\_\_ \_\_\_\_

Bulimia \_\_\_\_ \_\_\_\_ \_\_\_\_

Anorexia \_\_\_\_ \_\_\_\_ \_\_\_\_

Acid reflux \_\_\_\_ \_\_\_\_ \_\_\_\_

Excessive gas/indigestion \_\_\_\_ \_\_\_\_ \_\_\_\_

Cancer \_\_\_\_ \_\_\_\_ \_\_\_\_

Rheumatoid arthritis \_\_\_\_ \_\_\_\_ \_\_\_\_

Osteoarthritis \_\_\_\_ \_\_\_\_ \_\_\_\_

HIV \_\_\_\_ \_\_\_\_ \_\_\_\_

Asthma \_\_\_\_ \_\_\_\_ \_\_\_\_

Emphysema \_\_\_\_ \_\_\_\_ \_\_\_\_

Back Pain \_\_\_\_ \_\_\_\_ \_\_\_\_

Injuries \_\_\_\_ \_\_\_\_ \_\_\_\_

High blood pressure \_\_\_\_ \_\_\_\_ \_\_\_\_

Osteoporosis \_\_\_\_ \_\_\_\_ \_\_\_\_

Anemia \_\_\_\_ \_\_\_\_ \_\_\_\_

Concussion \_\_\_\_ \_\_\_\_ \_\_\_\_

Epilepsy \_\_\_\_ \_\_\_\_ \_\_\_\_

Eye problems \_\_\_\_ \_\_\_\_ \_\_\_\_

Hypoglycemia \_\_\_\_ \_\_\_\_ \_\_\_\_

Kidney problems \_\_\_\_ \_\_\_\_ \_\_\_\_

Thyroid problems \_\_\_\_ \_\_\_\_ \_\_\_\_

Ulcers \_\_\_\_ \_\_\_\_ \_\_\_\_

Inflammatory bowel disease \_\_\_\_ \_\_\_\_ \_\_\_\_

Neck strain \_\_\_\_ \_\_\_\_ \_\_\_\_

Stroke \_\_\_\_ \_\_\_\_ \_\_\_\_

Spinal cord damage \_\_\_\_ \_\_\_\_ \_\_\_\_

Vertebral disc problems \_\_\_\_ \_\_\_\_ \_\_\_\_

Peripheral artery disease \_\_\_\_ \_\_\_\_ \_\_\_\_

Other \_\_\_\_ \_\_\_\_ \_\_\_\_

Are you diabetic?

Do you often feel faint or have spells of severe dizziness?

Do you have a bone or joint problem that is made worse by exercise?

Do you suffer any chest discomfort with exertion, and have you ever suffered chest pain with an increased activity or at rest?

Do you use tobacco?

Have you used tobacco in the last 10 years?

Has your doctor ever said you have heart trouble or any cardiovascular problems?

Have you ever suffered a heart attack?

Do you often have trouble breathing?

Is your doctor currently prescribing any drugs for any heart condition including rhythm, blood pressure, coronary artery disease, or high cholesterol?

Has any family member died of a heart attack before age 50? Include your parents, grandparents, and siblings.

What is your most recent blood pressure reading? When was it taken and by whom?

What is your current resting heart rate?

Have you been diagnosed as having bradycardia (too low of a heart rate) or tachycardia (too fast of a heart rate)?

What is the date of your last complete physical examination?

List surgeries that you had, including any operations on your back, eyes, hernia, bones, heart, kidneys, neck, ears, lungs, etc.

Have you had any surgeries in the past three months? If so, what type?

List current medications, if any:

Have you any limitations in your range of motion of any of your limbs, or your torso?