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?

_____

Lifestyle and Health History Questionnaire

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?

_____

Additional Notes:

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