**LIFESTYLE AND HEALTH QUESTIONAIRE**

**CLIENT PERSONAL INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Gender: \_\_\_\_ Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_

Physician Name & Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXERCISE:**

What exercise activities do you currently take part in (i.e., running, weightlifting, group exercise, etc.)?

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How many days per week do you get at least 60 minutes of moderate-intensity exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On a scale of *0 to 10*** (0 being not at all with 10 being absolutely), how important are the following fitness goals to you?

Weight Loss: \_\_\_\_\_ Muscle Gain: \_\_\_\_\_ Sport Performance: \_\_\_\_\_ Health Improvement: \_\_\_\_\_ Functional Movement: \_\_\_\_\_ Competitive Body Building: \_\_\_\_\_

**DIET:**

**On a scale of *0 to 10*** (0 being unhealthy and 10 being healthy) would you rate your current, overall dietary intake? \_\_\_\_\_

Are you currently following a specific diet? If so, what diet are you following and for what reasons? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current salt intake: low, medium, or high? \_\_\_\_\_

How would you rank your daily sugar intake (includes beverages): Low, medium, or high? \_\_\_\_\_

How would you rank your daily fat intake: low, medium, or high? \_\_\_\_\_

How would you rank your daily protein intake: low, medium, or high? \_\_\_\_\_

How would you rank your carb intake: low, medium, high? \_\_\_\_\_

On average, how many ounces of water are you consuming per day? \_\_\_\_\_

**On a scale of *0 to 10*** (0 being not at all and 10 being not even a nibble) are you able to control your temptations for junk food? \_\_\_\_\_

How many alcoholic drinks do you consume per week? \_\_\_\_\_

How many caffeinated beverages do you consume daily (coffee, tea, energy drinks or caffeinated supplements)? \_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE:**

How many hours of sleep per night are you averaging: \_\_\_\_\_ Do you feel this is enough to feel rested each day? \_\_\_\_\_

**On a scale of *0 to 10*** (0 being none and 10 being maxed) how would you rate your average level of stress? \_\_\_\_\_

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

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Do you smoke/vape or chew tobacco products? \_\_\_\_\_ If yes, how many cigarettes per day? \_\_\_\_\_ How often do you replace your vape? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATION:**

What is your occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

**RECREATION:**

Do you participate in any recreational, physical activities (golf, skiing, snowboarding, etc.)? (If YES, please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**MEDICAL:**

Please list ALL (current or past) musculoskeletal injuries (broken bones, torn ligaments, sprains, strains): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list ANY past surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you have experienced injuries or undergone surgeries, were they properly rehabilitated? \_\_\_\_ Did you receive clearance from a doctor to return to physical activity? \_\_\_\_\_

Have you been diagnosed with diabetes? (If YES, please clarify; TYPE 1 or TYPE 2):

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If YES, are you insulin dependent: \_\_\_\_\_ Do you take oral medication? \_\_\_\_\_ (If YES, please explain which oral med you take\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with Hypertension? \_\_\_\_\_ (If YES, please list any medications you are taking to control it): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you been diagnosed with cardiovascular disease? \_\_\_\_\_ (If YES, please list any medications you are currently taking to manage it): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle and Health Questionnaire Additional Notes:**

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**Trainer Notes:**

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**~ Thank you for completing this Lifestyle and Health Questionnaire ~**