Weight Loss, Prevention & Diabetes Management Program
Health and Fitness Questionnaire

PERSONAL INFORMATION

Client Name ______________________________ Date ____________

Home Phone ______________ Work Phone ________ Cell ____________

Date of Birth ______________ Marital Status __________________

Physician _________________ Physician's Phone ________________

Physician's Address __________ City ______________ Postal Code _______

ACTIVITY SURVEY

Please check all the recreational or daily activities you participate in

- ☐ Martial Arts ☐ Cycle ☐ Walking ☐ Jogging
- ☐ Swim ☐ Soccer ☐ Tennis ☐ Golf
- ☐ Basketball ☐ Hockey ☐ Dance ☐ Hiking
- ☐ Gardening ☐ Baseball/Softball ☐ Play with kids ☐ Cooking
- ☐ Housework ☐ Laundry ☐ Dishes ☐ Vacuuming
- ☐ Snow Removal ☐ Lawn Care ☐ Groceries ☐ Sweeping
- ☐ Play/walk with pets ☐ Other (Please Specify)

How often do you participate in the above activities on a weekly basis? ________

On average, how much time do you spend per activity? ____________________

Other than recreational activity, do you exercise regularly? Yes ☐ No ☐

If yes, how long have you been exercising regularly? ______________________

When you exercise or complete a strenuous activity do you experience any of these symptoms?

☐ Leg Cramps ☐ Dizziness ☐ Pain in neck ☐ Upper Back Pain
☐ ☐ ☐

☐ Swelling of Joints Headache Pain in Jaw Pain in Chest
☐ Coughing ☐ Shoulder Pain ☐ Pain in Hips ☐ Pain in Knees
☐ Shortness of Breath ☐ Fatigue

Are you presently taking any form of medication? Yes ☐ No ☐

If yes, what medications are you currently taking? ___________________________

Has your doctor ever told you that you have heart or lung problems? Yes ☐ No ☐

If yes, describe: ____

Describe your health and fitness goals: (i.e. if your goal is to manage your blood glucose level – to what level, by when)

1. ____
2. ____
3. ____

IMPORTANCE OF ACHIEVING RESULTS

On a scale of 1 to 10 (10 being the most important) please rate by circling the number to indicate how important it is for you to achieve results in each category

Least Important ← → Most Important

Manage Symptoms	1	2	3	4	5	6	7	8	9	10
Prevent Disease	1	2	3	4	5	6	7	8	9	10
Weight Loss	1	2	3	4	5	6	7	8	9	10
Weight Gain	1	2	3	4	5	6	7	8	9	10
Improve Cardio	1	2	3	4	5	6	7	8	9	10
Tone Up	1	2	3	4	5	6	7	8	9	10
Build Muscle	1	2	3	4	5	6	7	8	9	10
Improve Posture	1	2	3	4	5	6	7	8	9	10
Increase Strength	1	2	3	4	5	6	7	8	9	10
Increase Flexibility	1	2	3	4	5	6	7	8	9	10
Reduce Stress	1	2	3	4	5	6	7	8	9	10
Fat Loss	1	2	3	4	5	6	7	8	9	10
Improve Self-Confidence	1	2	3	4	5	6	7	8	9	10
Feel Good	1	2	3	4	5	6	7	8	9	10
Increase Energy Levels	1	2	3	4	5	6	7	8	9	10
Improve co-ordination	1	2	3	4	5	6	7	8	9	10

Are you pleased with your current physical state? Yes ☐ No ☐

What is your current weight?____________What is your desired weight?________

What is your height? __________________

How long ago were you satisfied with your physical state?____________________

Does your physical shape and the way your body looks today prevent you from taking part in any activities ie. Swimming in public etc.? Yes ☐ No ☐

If yes, please describe: ____

What do you like about your body? ______________________________________

What do you not like about your body? ___________________________________

PAST WORKOUT EXPERIENCE

In the past 6 months how much have you been exercising?

☐ Not at all ☐ 1-2 x per week ☐ 3-4 x per week ☐ 5+ x per week

What has your past exercise sessions consisted of?

☐ Cardio Training ☐ Strength Training ☐ Flexibility ☐ Swimming ☐ Yoga
☐ Spin Classes ☐ Aerobics Classes ☐ Other (specify) __________________

LIFESTYLE SURVEY

Occupation ____________Description of work performed ___________________

Number of hours worked per week _____________________________________

Do you find your occupation stressful? Yes ☐ No ☐

If yes, why? ____

What do you do to relieve your stress? __________________________________

Have you ever smoked? Yes ☐ No ☐ If yes, for how long? ____________

On average how many cigarettes did you smoke per day? __________________

Do you presently smoke? Yes ☐ No ☐

If yes, on average how much do you spend on cigarettes per week? __________

How would you rate your sleep pattern? Good Average Poor

On average, how many hours of sleep do you receive per day? _______________

Do you wake up feeling rested? Yes ☐ No ☐

How many hours do you spend daily, on average:

Driving ______ Watching T.V.________ Reading________ At the Computer________

Do you have children? Yes ☐ No ☐ How many? ___________________

Does your current health affect your life at home? Please describe.

____

____

What are some of your interests and hobbies? ______________________________

____

How would you rate your energy levels throughout the day?

Morning:	☐ High	☐ Moderate	☐ Low
Afternoon:	☐ High	☐ Moderate	☐ Low
Night:	☐ High	☐ Moderate	☐ Low

MEDICAL BACKGROUND SURVEY

Do any of the following conditions relate to you?

☐ Arthritis	☐ Neck or Back Pain	☐ Dizziness	☐ High Blood Pressure
☐ Cholesterol Problems	☐ Hyper Thyroid	☐ Hypo Thyroid	☐ Hernia
☐ Low Blood Pressure	☐ Shortness of Breath	☐ Allergies	☐ Anemia
☐ Rheumatism	☐ Rheumatic Fever	☐ Heart/Chest Pain	☐ Bone/Joint Problems
☐ Gastrointestinal Problems	☐ Emphysema	☐ Water Retention	☐ Heat Disease
☐ Diabetes	☐ Epilepsy	☐ Varicose Veins	☐ Heart Trouble
☐ Coronary Artery Disease	☐ Myocardial Infarction	☐ Stroke	☐ Angina
☐ Chronic Heart Failure	☐ Asthma	☐ Irregular Bowel Movements	

Have you had recent surgery? Yes ☐ No ☐

If yes, describe: ____

Are you sensitive to touch/pressure anywhere? ______________________________

Do you experience numbness in any part of the body (i.e. feet)? _______________

Do you experience frequent headaches? Yes ☐ No ☐

Do you have high cholesterol? Yes ☐ No ☐

Are you undergoing any other type of treatment(s)? Yes☐ No ☐

If yes, please specify: ____

DIET SURVEY

Please list all the foods you ate yesterday and the approximate times or each meal or snack

1. ____Time__________________

2. ____Time__________________

3. ____Time__________________

4. ____Time__________________

5. ____Time__________________

6. ____Time__________________

7.____Time__________________

8. ____Time__________________

9. ____Time__________________

10.____Time__________________

On average, how many glasses of water do you drink per day? _______________

On average, how many cups of coffee/tea do you drink per day? ______________

On average, how many alcoholic drinks do you drink per week? ______________

Do you take vitamins or nutritional supplements? Yes ☐ No ☐

If yes, what do you take? ____

I certify that I have answered this Health and Fitness Questionnaire accurately to the best of my knowledge.

Client's Signature: ____