Health/Fitness History (Confidential Information)

Date_____
Name _____
Address (Street, City, ST, Zip)_____
Email_____
Home Phone_____
Work Phone_____
Occupation_____
Age_____Date of Birth_____
Sex M / F
Height_____Weight_____ Goal Weight_____
Drug or Food Allergies_____
Referred By_____

Physician Information

Physician's Name_____
Has your physician referred you to an exercise program? Yes / No
Has your physician cleared you for exercise? Yes / No / No Physician Comment

Personal Health History

Please list medical issues_____
_____

Medications

Are you currently taking any medications? Yes / No
If yes, please list medication:_____
_____

General Health Status

Do you presently feel that you are in good health? Yes / No
Do you have stress in your life right now? Yes / No
How many hours of sleep do you get a night?_____
Other comments_____
_____

Personal Habits

Do you smoke at present? Yes / No
Have you ever smoked? Yes / No
If yes, when did you quit?_____Years smoked?_____
If currently smoking, would you like to quit? Yes / No

Exercise

Do you currently engage in any form of regular exercise? Yes / No
If yes, please specify:_____
Please list at least three goals you wish to achieve through your personal fitness program, in order of importance: 1._____ 2._____ 3._____
What types of activities do you enjoy?_____
Are there any activities that you would like to try that you have never done before?_____
_____
Are there any other comments or concerns we need to know prior to your starting a personal fitness program?_____
_____

Nutrition

Diet/Nutrition History (Confidential Information)

What do you consider a good weight for yourself?_____
What is the most you have ever weighed?_____
Number of meals you eat per day?_____
How many times a day do you eat out (all meals included)?_____
Do you pack your lunch? Yes / No
Do you do the cooking at home? Yes / No
Do you drink alcoholic beverages? Yes / No How many per day? _____
Do you use salt? Yes / No
Do you drink coffee, tea or colas? Yes / No How many cups/glasses per day?_____
Do you take supplements? Yes / No If yes, please list:_____
_____
Are you on a special diet now? Yes / No If yes, explain: _____
_____
Approximately how many 8 oz. glasses of water do you drink per day?_____
Would you consider the portion size of your meals to be: Small / Medium / Large
Which is the biggest meal of the day? Breakfast / Lunch / Dinner
Do you clean your plate? Yes / No
What kind of snacks do you choose?_____
Approximately how many servings of fruit do you eat per day?_____
Approximately how many servings of vegetables do you eat per day?_____
Do you read food labels? Yes / No
Do you consider your meals to be balanced? Yes / No
How many meals a day do you eat sitting down at a table?_____
How many meals a day do you eat on the run?_____
Do you watch TV, read or listen to music when you eat? Yes / No
Do you use artificial sweeteners? Yes / No
How is your pace of eating? Slow / Medium / Fast
What do you feel is your trouble spot with your diet?_____
What are your nutrition goals? _____
_____

Please fill out a 24 hr Food Recall Sheet before your appointment

Food Name	**Portion Size**	**Comments**
Breakfast:		
Lunch:		
Dinner:		
Snacks:		
Exercise: _____	Activities: _____	
Supplements_____	# of oz of water_____	