



Please take your time and give thought to each question before you answer. The more detailed and accurate your responses, the better the service we can provide. You are not required to answer any other questions and all information will be kept confidential.

### Personal Information:

Name: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
 Marital Status: Single  Married  Children: Yes  No   
 Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### Occupation:

What is your occupation? \_\_\_\_\_  
 With respect to *physical* activity, how would you classify your work?  
 Very active , Reasonably active , Light , Sedentary   
 How often is your job mentally stressful?  
 Always , Frequently , Seldom , Never

### Physical Activity:

How would you describe your fitness level?  
 Excellent , Good , O.K. , Fair , Poor   
 How often do you take part in physical activity? (minimum of 15 minute sessions)  
 6-7 times/week , 4-5 times/week , 2-3 times/week , less than 2 times/week   
 In what activities do you participate? (e.g. hiking, walking, basketball, volleyball, etc.)  
 What activities would you like to become involved in? (e.g. tennis, triathlons, aerobics, etc.)

### Wellness:

How do you typically feel? (Choose one or more)  
 Healthy , Fit , Sickly , Tired , Low Energy , High Energy   
 How do you feel about your body image?  
 Excellent , Good , O.K. , Fair , Poor   
 Please rate the following:  
 Self Esteem: Excellent , Good , O.K. , Fair , Poor   
 Self Motivation: Excellent , Good , O.K. , Fair , Poor   
 In general, rate your sleep in terms of:  
 Hours/night: \_\_\_\_\_ (Weekends too? Yes , No  If no, \_\_\_\_\_ hours)  
 Restfulness: Excellent , Good , O.K. , Fair , Poor   
 What are two major stresses in your life?  
 \_\_\_\_\_

### Smoking:

Do you smoke? Daily , Occasionally , Never   
 If a daily smoker, specify the average amount you smoke per day: \_\_\_\_\_ cigarettes

If an ex-smoker, how long since you quit? \_\_\_\_\_ years and/or \_\_\_\_\_ months

**Drinking Habits:**

Do you drink alcohol? Yes  , No

If your response was 'yes', how many days per week do you drink? 1 , 2 , 3 , 4 , 5 , 6 , 7 +

Average number of drinks per day? 1 , 2 , 3 , 4 , 5 , 6 , 7 +

**Nutrition:**

Describe your nutrition habits: Excellent , Good , O.K. , Fair , Poor

Would you like to have your diet analyzed for it's nutritional value? Yes , No

Are you currently on any type of diet plan? Yes , No

If yes, please name/describe it (i.e. high protein, calorie reduced, Slimfast) \_\_\_\_\_

Have you ever been on a calorie reduced diet? Yes , No  If 'yes', describe: \_\_\_\_\_

How often do you eat per day? 4-7 times , 2-3 times , 1 -4 times, but irregular

How often do you salt your food? Always , Frequently , Occasionally , Seldom , Never

How often do you eat sweets foods? (i.e. deserts, pastries, chocolate, etc.)

Daily , 2-3 times/week , Weekly , Monthly , Never

Do you drink coffee? Yes , No  If yes how many cups per day? \_\_\_\_\_

**General Health:**

Describe your present state of health? Excellent , Good , O.K. , Fair , Poor

Do you have any allergies? Yes , No  If Yes, please specify: \_\_\_\_\_

Do you have any of the following?

Back Pain , Joint/Tendon/Muscle Pain , Lung Disease (asthma, emphysema, other)

Please explain: \_\_\_\_\_

Do you have any medical conditions for which a physician has ever recommended some restrictions on activity (including surgery)? Yes , No

Please explain: \_\_\_\_\_

Do you a have family history health problem (i.e. heart trouble, stroke, etc)? Yes , No

Please explain: \_\_\_\_\_

Do you take prescription or non-prescription medication regularly or with high frequency? Yes , No

If 'Yes', please specify:

Pharmaceutical Name	Frequency	Dosage (mg)
_____	_____	_____
_____	_____	_____

**Females Only**

Do you suffer from any menstrual dysfunction (physical or emotional)? Yes , No

Comment: \_\_\_\_\_

**Are you pregnant?** Yes , No

Please list any additional information that may assist us in regards to your present health and fitness status:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_

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