

CONFIDENTIAL

HEALTH, NUTRITION, AND FITNESS QUESTIONNAIRE

Date _____

Name _____ Age _____ Gender _____ Email _____

Phone number _____

HEALTH GOALS

1. Please describe your major health, nutrition, and/or fitness goals: _____

2. What are the two to three biggest barriers to achieving these goals? _____

3. What are the two to three greatest strengths that will help you to achieve these goals? _____

4. Please check the box that best describes how ready you are to make changes to your lifestyle to achieve these goals.

Do not believe I need to change

Would like to change, but don't think that I can

Will make changes soon

Recently started to make changes (past 6 months)

Would like to intensify changes

Made changes, but relapsed

5. On a scale of 1–10, how important is this change to you? _____

6. On a scale of 1–10, how confident are you that you will achieve this change? _____

MEDICAL INFORMATION

7. How would you describe your health? Excellent Good Fair Poor

8. Are you taking any prescription or over-the-counter medications or dietary herbs or supplements? Yes No

If yes, please list the medications and state the reason for taking: _____

9. When was the last time you visited your physician? _____

10. Do I have permission to communicate with your physician? Yes No

If yes, please state your physician's name and contact phone number. See HIPAA release form.

11. Do you have or has your doctor or another licensed healthcare professional told you that you have any of the following conditions?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies
(specify: _____) | <input type="checkbox"/> Chronic sinus condition | <input type="checkbox"/> Hyper/hypo-thyroidism | <input type="checkbox"/> Surgeries
Describe: _____ |
| <input type="checkbox"/> Amenorrhea or absence
of menstrual period
>3 months | <input type="checkbox"/> Cigarette smoker | <input type="checkbox"/> Hypoglycemia | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Past injuries
Describe: _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Intestinal problems | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Describe any other health
conditions you have,
or for which you take
medication:

_____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Disordered eating | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Intestinal problems | <input type="checkbox"/> Polycystic ovary disease | |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Gastroesophageal reflux
disease (GERD) | <input type="checkbox"/> Currently pregnant or
<3 months postpartum | |
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> High blood pressure/
hypertension | <input type="checkbox"/> Skin problems
Describe: _____ | _____ |
| | <input type="checkbox"/> High cholesterol | _____ | _____ |

12. Has anyone in your immediate family been diagnosed with any of the following? If yes, please describe.

- | | Relationship (e.g., father) | Age of diagnosis |
|--|-----------------------------|------------------|
| <input type="checkbox"/> Heart disease | _____ | _____ |
| <input type="checkbox"/> High cholesterol | _____ | _____ |
| <input type="checkbox"/> High blood pressure | _____ | _____ |
| <input type="checkbox"/> Cancer | _____ | _____ |
| <input type="checkbox"/> Diabetes | _____ | _____ |
| <input type="checkbox"/> Osteoporosis | _____ | _____ |

NUTRITION HISTORY

13. Have you ever followed a modified diet to manage a health condition? Yes No

If yes, please describe: _____

14. Do you follow a specialized diet (low-carb, gluten-free, vegan, etc). Yes No

If yes, please describe the diet and reasons for following: _____

Was the diet prescribed by a physician? Yes No

15. Who purchases and prepares your food? _____

PHYSICAL-ACTIVITY HISTORY

16. Are you currently physically active? Yes No

If yes, please describe: _____ minutes of cardiovascular activity, _____ times per week
 _____ minutes of strength or resistance training, _____ times per week
 _____ minutes of flexibility training, _____ times per week

17. Please list your favorite physical activities: _____

WEIGHT HISTORY

18. What would you like to do regarding your weight? Lose Maintain Gain

19. What was your lowest weight in the past five years? _____ Your highest? _____

20. What is your current weight? _____ What is your height? _____

OTHER

Is there any other information that you think I should know? Please use this space. _____

Thank you for your time and for sharing this information. It will be used to help develop a plan that will best meet your needs and help you to safely achieve your goals.