# Client Health Questionnaire

FITBODIES 4 LIFE™

## NOTE FROM COACH:

This questionnaire will allow me to get to know your current health and fitness state. Please answer it to the best of your abilities and be as honest as possible. The key to the success of any health program is the open communication from a client and their coach. If you have any questions please do not hesitate to email or call me.

## CLIENT INFORMATION :

Name _____

Phone Number _____

Address _____

Email _____

IG Handle/Facebook _____

DOB _____

Date _____

Height _____

Weight _____

BF% **(If known)** _____

Gender

**(Female) Measurements:**

**Waist:** **Hips:** **Thighs:** **Chest:**

**Neck:** **Waist :** **Hips:** **Thighs:**

## WEEKLY EXERCISE INFORMATION:

Please explain what type of resistance exercises, cardiovascular, or sports activities you perform over a 7-day period.

Exercise Activity:

_____

**What time do you weight train?** Days/ Week _____ Duration _____

## LIFESTYLE/PROFESSIONAL ACTIVITY:

How would you rate the level of your profession, or what you do during the day?

Sedentary ☐ Moderate Active ☐ Active ☐ Very Active ☐

## WHAT ARE YOUR GOALS?

Lose Weight ☐ Gain Weight ☐ Maintain/Improve Eating Habits ☐ Sport Specific ☐ Improve Flexibility ☐

Muscular Strength/Size ☐ Injury Rehab ☐ Goal Weight ☐ Compete ☐ Competition Date _____

## BODY TYPE

Which of the following statements best describes you?

☐ I can practically eat anything I want and don't gain weight.

☐ I can lose or gain weight by adjusting my activity level.

☐ I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

What time do you wake up? _____ What time do you go to sleep? _____

Do you smoke cigarettes? Y / N How many per day? _____ For how long? _____

Do you drink alcoholic beverages? Y / N

If so, what type of drinks and how many per day? _____

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FITBODIES LIFE

## HEALTH & MEDICAL CONDTIONS

- [ ] Heart Disease
- [ ] Anemia
- [ ] Hypoglycemia
- [ ] Liver Disease
- [ ] Kidney Disease
- [ ] Diabetes
- [ ] Pancreatic Disease
- [ ] Lactation
- [ ] Hypertension
- [ ] Abnormal EKG
- [ ] Arthritis
- [ ] Stroke
- [ ] Rheumatic Fever
- [ ] Bursitis
- [ ] Headache/Migraine
- [ ] Low Blood Pressure
- [ ] Asthma
- [ ] Emphysema
- [ ] Hernia
- [ ] Fatigue
- [ ] Foot Problems
- [ ] Back Problems
- [ ] Stomach Problems
- [ ] Shoulder Problems
- [ ] Knee Problems
- [ ] Lung Problems
- [ ] Recent Broken Bones
- [ ] Osteoporosis
- [ ] Leukemia or Cancer
- [ ] Are you pregnant? Y/N
- [ ] Swollen/Painful Joints
- [ ] Abnormal Chest X-Ray

Any other health problems or concerns not mentioned above? Please Describe:

_____

## PLEASE INDICATE ANY MEDICATIONS YOU ARE TAKING?

- [ ] Diurectics
- [ ] Beta- Blockers
- [ ] Vasodilators
- [ ] Cholestorol Meds
- [ ] Alpha Blockers
- [ ] Thyroid Meds
- [ ] Diabetes/Insulin
- [ ] Calcium Channel Blockers
- [ ] NSAIDS/ Anti-inflamatory

Any other medications for other condtions? Please Describe:

_____

_____

_____

## OTHER QUESTIONS

Do you have history of any kind of heart disease?

_____

Do you have history of any kind of metabolic disease (thyroid)?

_____

Have you experience any kind of chest pain?

_____

Shortness of breath during exercise?

_____

Have you ever suffered from any problems with faint or dizziness?

_____

Do you have difficulty breathing while standing?

_____

Do you suffer from sleep apnea?

_____

Do you suffer from ankle edema?

_____

Do you have a known heart murmur?

_____

Have you ever experienced severe pain in leg muscles while walking?

_____

Do you have a family history accelerated heart beat or flutters?

_____

Do you have a family history of cardiac or pulmonary disease prior to the age of 55?

_____

Have your serum cholesterol level been measured greater than 240mg/dl?

_____

Have your HDL been measured greater than 60mg/dl?

_____

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## OTHER QUESTIONS

Any other medical condition you may have please list accurately for your safety and well being?

_____

_____

_____

## FOOD QUESTIONS

Please list below everything you eat in a 24 hour period. Include supplements, vitamins, snacks, beverages, water, and approximate amount.

1._____ Time:_____

2._____ Time:_____

3._____ Time:_____

4._____ Time:_____

5._____ Time:_____

6._____ Time:_____

7._____ Time:_____

8._____ Time:_____

List beverages that you consume daily and supplements.

_____

_____

_____

_____

_____

List any food allergies if any:

_____

_____

_____

_____

_____

# Client Health Questionnaire

Make your Favorite Food List

_____

_____

_____

_____

_____

How many meals a day would you prefer to eat?

Choose one:

4 meals _____

5 meals _____

6 meals _____